Arkansas

UNIFORM APPLICATION
FY 2008 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/20/2007 - Expires 08/31/2008

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_ FY2008 ___ FY 2008-2009 ___ FY 2008-2010

STATE NAME: Arkansas

DUNS #: 119841336

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health Services

STREET ADDRESS: 4313 West Markham Street

CITY: Little Rock, STATE: AR ZIP: 72205-4096

TELEPHONE: (501) 686-9164 FAX: (501) 686-9182

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Jay Bradford TITLE: Director, Division of Behavioral Health Services

AGENCY: Department of Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health Services

STREET ADDRESS: 4313 West Markham Street

CITY: Little Rock, STATE: AR ZIP CODE: 72205-4096

TELEPHONE: (501) 686-9164 FAX: (501) 686-9182

III. STATE FISCAL YEAR

FROM: 07/01/2007 TO: 06/30/2008

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: John Althoff, Ph.D. TITLE: Assistant Director, Adult Services

AGENCY: Department of Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health Services

STREET ADDRESS: 4313 West Markham Street

CITY: Little Rock, STATE: AR ZIP: 72205-4096

TELEPHONE: (501) 686-9166 FAX: (501) 686-9182 EMAIL: john.althoff@arkansas.gov

Arkansas

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

2008 MENTAL HEALTH BLOCK GRANT APPLIATION - ARKANSAS
EXECUTIVE SUMMARY

The Division of Behavioral Health Services (DBHS) is Arkansas' Single State Agency for both Mental Health and Substance Abuse Treatment/Prevention services. DBHS discharges its responsibility for the provision of public mental health services by operating the Arkansas State Hospital (ASH) and the Arkansas Health Center skilled nursing facility, by contracting with fifteen local, private non-profit Community Mental Health Centers (CMHCs), and by certifying three private non-profit specialty Community Mental Health Clinics. Each CMHC is responsible for providing a basic array of services to residents of a designated geographic area and serves as the single-point-of-entry to the public mental health system for its catchment area. DBHS is part of the Department of Health and Human Services (DHHS) and provides formal leadership for the public mental health system through its participation in the executive functions of state government. Of particular importance is DBHS' ongoing involvement with the DHHS' Division of Medical Services (Medicaid), the largest funder of public mental health services. DBHS also allies itself with other organizations to advance the cause of public mental health, including the Arkansas Mental Health Planning and Advisory Council (AMHPAC).

CHILDREN'S SERVICE SYSTEM

A major strength currently in the children's behavioral health system is our DHS initiative to transform children's behavioral health by developing a statewide system of care. In previous block grant applications and reports, Arkansas reported that the system for children is fragmented and lacks accountability, with bed-based care being utilized for a much higher number of children than can be justified. As a result of Act 2209 of 2005 requiring the development of a plan for a statewide system of care, a report was made to the Children and Youth Committee of the Arkansas Legislature in June 2006 that called for significant changes. The Director of DHS determined that the issue of children's behavioral health impacts all child-serving agencies and elevated this initiative to a Departmental level. A twenty-five member Stakeholders Committee was formed to advise DHS on the development of family and youth organizations, governance and financing and accountability for the children's behavioral health system. In the 2007 legislative session, Act 1593 was passed that requires the adoption of System of Care principles, the improvement of the children's behavioral health system and the development of a Governor appointed Commission to provide oversight of the children's behavioral health system. The Governor of Arkansas, Mike Beebe, strongly supported this legislation and has continued to support efforts to transform the system. As a result of this legislation, DBHS will have four new positions and more than one million dollars has been allocated to support system of care development.

The First Lady of Arkansas, Ginger Beebe, launched a "listening tour" in May and June, 2007 meeting with families of children with serious emotional disturbance. Mrs. Beebe went to twenty-two towns across Arkansas. Meetings were facilitated by family

members from NAMI-Arkansas, Federation of Children and Families and the Arkansas Mental Health Planning and Advisory Council. As a result, Arkansas has the beginning of a statewide family network that will be an integral component of the system of care development. Mrs. Beebe will formulate a report that will be presented to the newly-appointed Children Behavioral Health Commission on August 30, 2007.

Within the public mental health system, specific emphasis has been on school-based mental health services and early childhood mental health services. DBHS and the Department of Education are collaborating, by funding three school-based mental health grants that require the CMHCs to work collaboratively with identified schools to implement the evidence-based approach of Positive Behavioral Supports, on a school-wide basis, along with traditional mental health interventions in the school setting. Currently, demonstration projects focused on early childhood consultation with three CMHCs and local child care centers are in the third year. Although the grants are only with three CMHCs, the initiative has resulted in increasing expertise in early childhood mental health statewide, with training and technical assistance being provided to all CMHCs. The University of Arkansas for Medical Sciences is evaluating outcomes for these projects. Initial results indicate that positive changes are occurring through decreasing punitive behaviors by child care teachers.

DBHS Children's Services continues to work closely with the Division of Medical Services (DMS) and the Medicaid utilization review contractor regarding Medicaid funding of children's behavioral health services. As in most states, collaborative approaches between Medicaid and the mental health authority are essential since Medicaid funds a vast majority of the services for children. Medicaid requires that providers of rehabilitation option services and private mental health provider have certification by DBHS prior to enrollment as a Medicaid provider. Policy changes related to this certification process that will improve quality and increase accountability have been proposed and are expected to be promulgated in the fall.

ADULT SERVICE SYSTEM

Areas of previous state plan focus and related achievements include: promotion of the greater availability of evidenced-based practices (EBP), expansion of access to local acute inpatient care for adults, data system improvements, the role of Medicaid in financing mental health services, furthering the integration of mental health and substance abuse treatment, and replacing the Arkansas State Hospital with a new facility.

New developments and issues affecting the public mental health adult services system include: new funding to provide for the expansion of local acute inpatient capacity in under resourced areas of the state, ongoing developments in Medicaid, further enhancements in the data system, de-merger of the Department of Health and Department of Human Services, and the appointment of a new DBHS Director.

The primary strength of the adult comprehensive community-based system of care is the existence of a well established, stable group of public mental health providers- the 15

CMHCs and three Mental Health Clinics. All of the CMHCs are responsible for providing the basic array of crisis intervention/stabilization, clinical and rehabilitative services. Of course, the breadth of services within the basic array varies among Centers, and with few exceptions evidenced-based practices (EBP) with known fidelity to the practice model are not in place. It is a priority goal of DBHS to maintain the current programs that support the goals of a community-based system of care while promoting the initiation and dispersal of EBPs more widely throughout the system of care. DBHS plans to maintain a comprehensive community-based adult mental health system of care that minimizes inpatient hospital stays, in particular readmission's to ASH, and that delivers services to clients that are viewed by the clients (as measured by consumer satisfaction surveys) as being accessible and effective. Inpatient stays will be minimized by providing timely aftercare to those leaving the Arkansas State Hospital and by providing responsive ongoing case management to those clients most at-risk for hospitalization. In terms of EBP expansion, the first focus will be on the provision of Assertive Community Treatment (ACT).

DBHS will continue to monitor the penetration of the public mental health system in terms of providing services to its target population of adults with serious mental illness. As noted, DBHS has been involved in ongoing efforts to improve its data system. With the recent improvements in this system DBHS is now able, for the first time, to determine the unduplicated counts of individuals served and will have available the results of a statewide uniform consumer satisfaction survey based on a random sample of sufficient size to yield valid results.

A strength of Arkansas' public mental health system is that a number of providers have housing programs, some quite extensive. CMHC-controlled housing options are available to individuals with SMI that have become homeless or are at-risk of homelessness, although making services accessible to the homeless can be challenging. Another strength of the public mental health system is that Arkansas' public mental health system was developed and continues to serve its rural population through a widely disbursed system of care. DBHS plans to continue its emphasis on and monitoring of the level of services in rural areas and to the homeless.

To further all of these goals, DBHS will maintain the percent of funds under its control directed to community-based services.

Although the Division of Behavioral Health Services (DBHS) had undertaken some initiatives in the adult system of care that further some of the transformation goals outlined in the New Freedom Commission (NFC) report, including those focused on developing a recovery oriented system, this 2008 Block Grant Application represents DBHS' first systematic review and documentation of these mental health system transformation efforts. This review is organized around the 19 recommendations subsumed under the six NFC goals.

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2008

I hereby certify that Arkansas agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ _____

Governor Date
Mike Beebe, Governor, State of Arkansas

OMB Approval No. 0920-0428

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Governor, State of Arkansas
APPLICANT ORGANIZATION Department of Human Services, Division of Behavioral Health Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**Congressional District,** *if known:*
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** *if known:*	9. **Award Amount,** *if known:* **$**
10. a. **Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	b. **Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ''RFP-DE-90-001.''

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in con- struction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Governor, State of Arkansas
APPLICANT ORGANIZATION Department of Human Services, Division of Behavioral Health Services	DATE SUBMITTED

SF-424B (Rev. 7-97) Back

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2006	Estimate/Actual FY 2007
$2,955,792	$3,859,526	$3,831,184

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY __X__ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2005	Actual FY 2006	Actual/Estimate FY 2007
$64,369,127	**$65,731,068**	**$65,388,889**

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Allured, Robert	Family Members of Children with SED		4320 Dean Springs Rd. Alma,AR 72921 PH:479-632-3956 FAX:479-632-3819	raallured@cox.internet.com
Allured, Sharon	Family Members of Children with SED		4320 Dean Springs Rd. Alma,AR 72921 PH:479-632-3956 FAX:479-632-3819	
Arias, Cris	Providers		1125 N. College Fayetteville,AR 72703 PH:479-530-2574 FAX:479-713-7187	carias@wregional.com
Arnold, Kim	Others(not state employees or providers)	NAMI-Arkansas	712 W. 3rd Street Little Rock,AR 72201 PH:501-661-1548 FAX:	karnold@nami.org
Barnes, Betsy Lee	State Employees	Other	P. O. Box 1437, Slot S530 Little Rock,AR 72203 PH:501-683-6251 FAX:	Betsy.barnes@arkansas.gov
Brown, Ray A.	State Employees	Vocational Rehabilatation	105 Reserve Ave. P. O. Box 1358 Hot springs,AR 71902 PH:501-624-4411 FAX:	R.Brown@ARS.state.ar.us

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Burcham, Scott	Others(not state employees or providers)		P. O. Box 4073 State University,AR 72467 PH:870-972-3137 FAX:	Sburcham@astate.edu
Burklow, Chuck	Providers		P.O. Box 8902 Fayetteville,AR 72703 PH:479-521-5731 FAX:	chuckb@vistahealthservices.com
Castleberry, Anita	State Employees	Medicaid	P. O. Box 1437 Little Rock,AR 72203 PH:501-682-1671 FAX:	
Clemons, Michele R.	Family Members of Children with SED		1175 Hopper Redfield,AR 72132 PH:501-397-2430 FAX:	clemonsmichele@yahoo.com
Clemons III, Billy Ray	Consumers/Survivors/Ex-patients(C/S/X)	Youth Consumer	1175 Hopper Road Redfield,AR 72132 PH:501-397-2430 FAX:	ryu8462@yahoo.com
Cotton, Jannie	Providers		P. O. Box Drawer 24210 Little Rock,AR 72211 PH:501-221-1843 FAX:	Jannie.Cotton@pca.ar.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Cumblidge, Junie Sissy""	Family Members of adults with SMI		11001 donnie Drive Shannon Hills,AR 72103 PH:501-455-2174 FAX:	tomandsissy777@msn.com
Davis, Mona K.	State Employees	Social Services	700 Main St., Slot S570 Little Rock,AR 72223 PH:501-683-2044 FAX:	Mona.Davis@arkansas.gov
Davis, Vanessa	State Employees	Mental Health	4313 W. Markham Litle Rock,AR 72205 PH:501-686-9106 FAX:501-686-9182	vanessa.davis@arkansas.gov
Devers, Jessie	Family Members of adults with SMI		2988 Little Blakley Creek Road Jessieville,AR 71949 PH:501-984-7679 FAX:	
Donovan, Linda	State Employees	Other	2401 N University Little Rock,AR 72207 PH:501-661-1000 FAX:	Linda Donovan4945@msn.com
Green, Mae	Consumers/Survivors/Ex-patients(C/S/X)		5580 E. 4th St. #3 Mountain Home,AR 72653 PH:870-425-9657 FAX:	maeinar@cox.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Hatfield, Missa Hollis	Family Members of Children with SED	NAMI-Arkansas	712 West 3rd Street, Suitre 200 Little Rock,AR 72201 PH:501-661-1548 FAX:	mhatfield@nami.org
Johnson, Janice A.	Family Members of adults with SMI		P. O. Box 264 Diaz,AR 72043 PH:870-523-6328 FAX:	
Kearney, Janetta	Others(not state employees or providers)		P. O. Box 1008 Little Rock,AR 72203 PH:501-223-2714 FAX:	Kearneyconsulting@netzero.net
Mashburn, Scott	Consumers/Survivors/Ex-patients(C/S/X)		935 N. Highland Ave Fayetteville,AR 72701-2016 PH:479-443-9571 FAX:	s.mashburn@sbcglobal.net
Materson, Kerry C.	Consumers/Survivors/Ex-patients(C/S/X)		15209 Crystal Valley Little Rock,AR 72210 PH:501-455-1200 FAX:	kerrymasterso69@yahoo.com
Morgan, Darin D.	Providers		P.O. Box 23047 Barling,AR 72923 PH:479-452-5040 FAX:	dmorgan@pbhm.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Neece, Barbara M.	Family Members of adults with SMI		4008 E. Hwy. 45 Fort Smith,AR 72916 PH:479-648-1203 FAX:	Barb6319@aol.com
Neece, George W.	Family Members of adults with SMI		4008 E. Hwy 45 Fort Smith,AR 72916 PH:479-648-1203 FAX:	Buzz037@aol.com
Parker, Bob	State Employees	Criminal Justice	P. O. Box 8707 Pine Bluff,AR 71611 PH:870-357-8277 FAX:	
Parlier, Susan C.	Providers		12795 Fort Road West Fork,AR 72774 PH:479-839-2893 FAX:	sunshadow7@earthlink.net
Poulin, Esther May	Family Members of adults with SMI		7316 Grace Road Little Rock,AR 72207 PH:501-562-1571 FAX:	May poulin 222@hotmail.com
Pugh, Darlene Mary	Consumers/Survivors/Ex-patients(C/S/X)		2988 Little Blakley Creek Road Jessieville,AR 71949 PH:501-984-5012 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Reinmiller, Janet Elaine	Consumers/Survivors/Ex-patients(C/S/X)		724 N. Tyler Little Rock,AR 72205 PH:501-664-6499 FAX:	
Robbins, Wesley Charles	Providers		5537 Bleax Ave Springdale,AR 72762 PH:479-872-5580 FAX:	wrobbins@dayspringbhs.com
Robertson, J. B.	State Employees	Education	4 Capitol Mall Little Rock,AR 72201 PH:501-682-4354 FAX:	jrobertson@arkedu.k12.ar.us
Rodgers, SeRonna	Family Members of Children with SED	Disability Rights Center (State's P & A)	274 Flintstone Drive Bryant,AR 72022 PH:501-296-1775 FAX:	seronna@arkdisabilityrights.org
Rucker-Key, Georgia	Family Members of Children with SED		P.O. Box 45402 Little Rock,AR 72214 PH:501-223-2714 FAX:	Mrucker@sbcglobal.net
Shumaker, William	Consumers/Survivors/Ex-patients(C/S/X)		811 N. Spruce St. Little Rock,AR 72205 PH:501-666-0371 FAX:	rockshoe501@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Soularie, Joyce Louise	State Employees	Other	4313 W. Markham, Ste. 300 Little Rock,AR 72205 PH:501-683-0312 FAX:	Joyce.Soularie@arkansas.gov
Strauss, Rhonda Rouch	Consumers/Survivors/Ex-patients(C/S/X)		28 Compass Point North Little Rock,AR 72120 PH:501-835-3794 FAX:	
Sullivan, Jo Ann	Family Members of Children with SED		19 Purdue Circle Little Rock,AR 72204 PH:501-562-5284 FAX:	
Sullivan, Mark	Consumers/Survivors/Ex-patients(C/S/X)		2500 Kananaugh, 3-C Little Rock,AR 72205 PH:501-663-6026 FAX:	Mksullivan48@yahoo.com
Sullivan, Mike	Family Members of adults with SMI		4 Feldspar Court Little Rock,AR 72212 PH:501-224-9287 FAX:	Msullivan72212@comcast.com
Taylor, Angela	Family Members of Children with SED		6670 Hwy 321 E Austin,AR 72007 PH:501-224-9287 FAX:	angiet@cebridge.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Tobin, Joe	Consumers/Survivors/Ex-patients(C/S/X)		P. O. Box 1025 Mountain Home,AR 72654 PH: FAX:	joeinar@cox.net
Wesor, Kim	Consumers/Survivors/Ex-patients(C/S/X)		1175 Hopper Redfield,AR 72132 PH:501-397-2430 FAX:	
Whitlock, Kenny	Others(not state employees or providers)		501 Woodland, ste. 220 Little Rock,AR 72201 PH:501-372-7062 FAX:	KennyW@mhca.org
Wilson, Debra	Family Members of Children with SED		2988 Little Blakley Creek Road Jessieville,AR 71949 PH:501-984-7679 FAX:	
Wright, Frank Mic""	Providers		2617 Ozark Drive North Little Rock,AR 72116 PH:501-834-0766 FAX:	micnnate@aol.com

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	47	[redacted]
Consumers/Survivors/Ex-patients(C/S/X)	11	[redacted]
Family Members of Children with SED	9	[redacted]
Family Members of adults with SMI	7	[redacted]
Vacancies(C/S/X and Family Members)	0	[redacted]
Others(not state employees or providers)	4	[redacted]
TOTAL C/S/X, Family Members and Others	31	65.96**%**
State Employees	9	[redacted]
Providers	7	[redacted]
Vacancies	0	[redacted]
TOTAL State Employees and Providers	16	34.04**%**

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Arkansas

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

2008 Mental Health Block Grant Application – Arkansas
Part B. Administrative Requirements, Fiscal Planning Assumptions and Special Guidance
Section IV. State Mental Health Planning Council Requirements
3. Planning Council Charge, Role and Activities

Immediately below is the State Mental Health Planning Council's By-Laws which describe the organization's charge, and its policies and procedures for the selection of council members, their terms and the conduct of meetings.

Following the By-Laws is a memorandum from the Council's Chair which reports, for the past year, the Planning Council's efforts and related duties as mandated by law.

ARKANSAS MENTAL HEALTH PALNNNING ADVISORY COUNCIL

BY-LAWS

Article I. Name

Section 1.01

The name of the organization is the "Arkansas Mental Health Planning and Advisory Council" (AMHPAC). Collectively, all persons who are appointed as members comprise the Arkansas Mental Health Planning and Advisory Council. Each of these persons is also a member of one of five geographic Regions, which correspond with the Department of Human Services' geographical boundaries.

Article II. Duties

Section 2.01

As mandated in Public Law 102-321, cited from Section 1914, "(a) ...the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) ...the duties of the Council are: (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans; (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State."

Definition: Throughout these Bylaws, the term "Council" means a State mental health planning council. The "State Mental Health Planning Council" for Arkansas is named the "Arkansas Mental Health Planning and Advisory Council." "Executive Committee" means the Executive Committee of the Arkansas Mental Health Planning Advisory Council.

Article III. Responsibilities

Section 3.01

The Arkansas Mental Health Planning and Advisory Council's responsibilities to improve the service delivery in the public mental health system have been identified as:

- to act on concerns that are paramount commonalities in each region, as identified during a series of mental health forums that target consumers and families;
- to identify and assist in the design of pilot programs for specialized services, including prevention services, within their respective region;
- to present position papers to the Division of Behavioral Health Services ("the Division") regarding recommendations for implementation of such specialized programs and/or services;
- to assist the Division to design a system of care to meet the needs of the consumers by matching resources and choices to maximize the consumers' health and quality of life;
- to build a more comprehensive and appropriate network for future needs;

- to plan and advise on policies, procedures, mandates, and regulations set forth by the Division of Behavioral Health Services / Department of Human Services.
- to advocate for the provision of mental health services to persons of all ages with serious mental illness and other mental health needs, particularly as it relates to managed care and the imminent changes in national mental health systems; and
- to network with local communities (i.e., municipal leagues, chambers of commerce, church groups, volunteer agencies, etc.) to help assure the accessibility of services for clients of the mental health system throughout the state.

Article IV. Membership and General Structure

Section 4.01 Composition

As mandated in Public Law 102-321, cited from Section 1914 C Membership -- "(1) In General … The Council [will] be composed of residents of the State, including representatives of --
(A) the principal State agencies with respect to -- (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and (ii) the development of the plan submitted pursuant to the Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance."
As mandated by the same Public Law, (a) the ratio indicating parents of children with a serious emotional disturbance to other members of the Council shall be sufficient to provide adequate representation of such children in the deliberations of the Council. At least one member may be a representative from the Child and Adolescent Service Systems Program (CASSP). Each Region shall recruit parents of children with a serious emotional disturbance to provide adequate representation of such children in the deliberation of the Council; and (b) at least 50 per cent of the members of the Council shall be individuals who are not State employees and not providers of mental health services. This 50 per cent requirement will be applied to the Council as a whole, although each Region is encouraged to attempt to maintain a similar balance.

Section 4.02: Appointment of Members

It shall be the responsibility of the Director of the Division of Behavioral Health Services to authorize appointments to the Council. Each Region shall submit nominations of prospective members to the Director of the Division of Behavioral Health Services. The Nominating Committee of the Region shall recommend prospective members to the Region, and additional nominations will be accepted from the body during Region meetings. The Region members will vote whether to submit each prospective member's name as the Region's recommendation to the Director of the Division of Behavioral Health Services. (see policy)

Section 4.03: Terms of Membership

A member may resign before the end of his or her term by sending written notice to the Chair of their Region. The Region Chair may ask the member to reconsider, but if the member does not wish to withdraw the resignation, the Region Chair will notify the State Chair, who will notify the Executive Committee and the Director of the Division of Behavioral Health Services of the resignation.

Section 4.04: Voting Powers

Within each respective region, members of that region have power to vote. For meetings of the Council as a whole or of the Executive Committee, each Region has a single vote. In the event that the selected designee does not attend the Region forfeits its vote. It is the Regions responsibility to notify the Executive Committee of their designee, and alternate voting representative in writing. In unforeseen circumstances, when a representative and alternate cannot attend, written communication on results of any vote can be sent to the AMHPAC Administrative Assistant; who will forward the communication to the Executive Committee and the Director of the Division of Behavioral Health Services. Members of each Region must

decide by majority vote or by consensus, what instructions to give their representative for casting the Region's vote.

Section 4.05: Membership Meetings

The Arkansas Mental Health Planning and Advisory Council membership will meet a minimum of four times per year, or as needed, for purposes such as: member education, systems planning, development of policies and procedures, and such other purposes as benefit from the participation of the entire group. These meetings are open to the public. Two weeks' written notice will be sent from Division of Behavioral Health Services to all Council members before such a meeting. At these meetings, each Region has a single vote, and time may be provided during the meeting for each Region to caucus and determine how to cast its vote. The Region vote will be given by the region designee or the alternate.

Section 4.06: Executive Committee

Each Region will vote to appoint one of its members to the Executive Committee of the Council. (See Article VI.) Meetings of this Executive Committee may coincide with Arkansas Mental Health Planning and Advisory Council membership events or may occur at other times. (The representative elected by the Region may be the region's chairperson, vice-chair, or another representative voted by the membership.) The term of Executive Committee members will be two years. Terms shall run from July 1 of each odd numbered year through June 30 of each odd numbered year. The Former State Chair is strongly encouraged to attend and participate in Executive Committee meetings. This is an ex officio non-voting position, unless the State Chair's Region elects to appoint him or her to carry the vote of that Region. The Vice Chair shall be expected to attend all Executive Committee meetings as a non-voting member.

The Executive Committee's responsibility is to discuss emerging problems, to take questions back to their Region for discussion, to bring concerns from their region, and to advise the Director of the Division of Behavioral Health Services in situations where a meeting of the whole Council is not feasible.

At meetings of the Executive Committee, each Region has one vote, and three of the five Regions must have a region designee or alternate attending for a quorum to be established. The Division of Behavioral Health Services will send written notice to all members of the Council before the meeting, including notice of the agenda to be discussed and/or questions to be addressed. (Any member of the Council may attend these meetings.) In the event that the selected designee or alternate doesn't come, the Region forfeits its vote. It is the Regions responsibility to notify the Executive Committee of their designee and alternate voting representative in writing. In unforeseen circumstances when a representative and alternate cannot attend, written communication on results of any vote can be send to the AMHPAC Administrative Assistant who will then sent the communication to the Executive Committee and the Director of the Division of Behavioral Health Services.

Only the Director of the Division of Behavioral Health Services can call an emergency meeting of the Executive Committee. In the event of an emergency, a meeting by teleconference may be held. If no representative of a particular Region can attend, a written proxy vote may be sent from the Region to the Chair of the Executive Committee by fax or mail to cast a vote on the issues to be discussed.

If a Region is not represented for two consecutive meetings, the State Chair shall contact the Region designee and alternate of record of that Region. After three consecutive absences, of the designee and alternate of the Executive Committee may be asked to resign from the Committee. Before recommending a member be removed from the Committee, the State Chair shall contract the member, consider the circumstances and ask the Committee to vote whether to recommend termination.

The Chair of the State Council may cast one vote to break a tie between regions

Section 4.07: Meetings of Regions

Each of the five Regions are expected to hold a minimum of four meetings a year. All members are expected to attend meetings of their own Region. After three consecutive absences, a member may be asked to resign Before recommending a member be terminated, the Region shall contact the member,

consider the circumstances, and vote whether to recommend termination. Recommendations will be presented to the State Chair who will forward the recommendation to the Director of the Division of Behavioral Health Services for approval.

If a Region has sub-regions, each sub-region is expected to meet a minimum of four meetings a year.

Article V. Minutes of Meetings

Section 5.01: Minutes of Executive Committee Meetings

The Chair of the Executive Committee Council will lead the meetings and ensure accurate minutes are maintained. Meetings shall be recorded and transcribed by support staff of the Division of Behavioral Health Services. Minutes shall be sent to each member of the Committee for review, and after minutes are approved by the Executive Committee, they shall be mailed by the Division of Behavioral Health Services to all Council members and added to the archive of Council minutes.

Section 5.02: Minutes of Region Meetings

The Secretary of each Region shall ensure an accurate summary of region meetings is maintained. Approved minutes of each meeting will be sent to all members of the region, distributed with State Meeting announcements, and copied to the Division of Behavioral Health Services, who shall maintain an archive of all regional minutes.

Article VI. Election of Officers

Section 6.01 Region Officers

Each Region shall elect a slate of officers for a term to be effective July 1 of each odd year through June 30 of each odd year. Officers shall include a Chair, a Vice-Chair, and a Secretary. A Co-Chair may additionally be elected if the Region prefers to share presiding duties among two individuals during a given term. The Region shall also elect a designee and an alternate to serve on the Executive Committee, who may be the same person as any of these officers or any other voting member of the Region.

Each Region may appoint a Nominating Committee or may accept nominations from the floor at a Region meeting. Although no quotas are set, efforts should be made to encourage as many consumers and family members as possible in leadership positions. If a Nominating Committee is used, additional nominations may be made from the floor at the election meeting. Election shall be by majority vote at a meeting of the Region membership, with notice of the time and place of the voting meeting mailed to all Region members at least four weeks in advance. For Region input to the State Elections see Section 6.02.

The Region designee or alternate shall report Region activities to the State Chair and the Executive Committee, who will report, as needed, to the Director of the Division of Behavioral Health Services for information and/or approval.

Section 6.02 Officers of the Statewide Council and of the Executive Committee

State Chair. A Chair of the Arkansas Mental Health Planning Advisory Council will be elected from among the current members in good standing. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each Region casting one vote. Procedures for the election shall be developed by the Executive Committee with the approval of the Director of the Division of Behavioral Health Services.

The term of the Council Chair will be two years, and four consecutive years may be served. To coordinate with the schedule of the State Legislature, the term shall begin July 1 of each odd-numbered year and end June 30 of each odd-numbered year.

This Chair will preside over meetings of the statewide Council membership, preside over meetings of the Executive Committee, and carry out such other responsibilities as are requested by the Director, Division of

Behavioral Health Services. At Executive Council meetings the Chair shall cast a vote only if needed to break a tie among the Regions voting.

Taking into consideration the abilities, interests, and resources available among the 5 persons serving on the Committee and among other Council members, the Executive Committee or the Director of the Division of Behavioral Health Services may assign other specific functions to the Chair as needed.

Vice Chair. A Vice Chair of the Arkansas Mental Health Planning and Advisory Council will be elected from among the current members in good standing. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each Region casting one vote. Procedures for the election shall be developed by the Executive Committee with the approval of the Director of the Division of Behavioral Health Services.

The term of the Council Vice Chair will be two years, and four consecutive years may be served. To coordinate with the schedule of the State Legislature, the term shall begin July 1 of each odd-numbered year and end June 30 of each odd-numbered year.

The Vice Chair will fulfill any duties of Chair as requested by the Chair, the Executive Committee or the Director of the DBHS.

The Vice Chair is not a voting member of the Executive Committee, unless he or she has also been selected by his or her Region to carry the vote of that Region.

Parliamentarian. The Parliamentarian of the Arkansas Mental Health Planning and Advisory Council will be elected from among the current members in good standing. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each Region casting one vote. Procedures for the election shall be developed by the Executive Committee with the approval of the Director of the Division of Behavioral Health Services.

The term of the Parliamentarian will be two years, and four consecutive years may be served. To coordinate with the schedule of the State Legislature, the term shall begin July 1 of each odd-numbered year and end June 30 of each odd-numbered year.

The Parliamentarian is not a voting member of the Executive Committee, but will be expected to attend such meetings.

The Parliamentarian will advise the chair and gives his/her opinion when asked or when he/she believes that the issue at hand is not in compliance with current by-laws. The Parliamentarian only advises, the chair maintains sole responsibility for ruling on a point of order or answering a parliamentary inquiry.

Article VII. Amendments to Bylaws

Section 7.01

Amendments to these Bylaws may be proposed at any regular meeting of the Executive Committee. The Executive Committee shall appoint an ad hoc committee to review the entire Bylaws and to recommend changes. The ad hoc committee shall prepare a description of changes being proposed, along with a list of all persons who participated in the review and revision. This shall be mailed to all AMHPAC members, along with a notice of date, time, and place that the Executive Committee will vote on the revisions. This notice shall be mailed no less than thirty days before the Executive Committee meeting.

At that meeting of the Executive Committee, any or all of the proposed revisions may be

adopted. A majority vote for this purpose shall be affirmative votes from no less than three Regions of the AMHPAC. (That is, regardless of the number of Regions present, a minimum of three affirmative votes are needed, and for this purpose the Chair may vote to break a tie only if the representative from the Chair's own Region is not present.) The revised Bylaws shall be immediately forwarded to the Director of the Division of Behavioral Health Services for final approval.

The State Chair shall ensure that the Bylaws are routinely reviewed at least every two years, if no changes have been proposed in that time.

Article VIII. Committees

Section 8.01 Arkansas Mental Health Planning and Advisory Council Committees

The Council shall have the power to establish committees to work on specific topics or issues. The committees can be abolished or created by Executive Committee, after consideration and majority vote by the regions. Persons who are not voting members of the Council may serve on committees at the recommendation of a region with approval by the State Chair. The committees may include, but will not be limited to (a) Legislative; (b) Education and Community Relations; (c) Advocacy; (d) Employment and Vocational Rehabilitation; (e) Transportation; and (f) Housing.

Section 8.02: Region Committees

Each Region shall have the power to establish and disband Region committees as needed. Persons who are not members of the Council may participate in these committees, as long as they do not vote in Region deliberations.

Section 9.01: Removal of Officers or Members

Elected officers at the State or Region level and members of the council can be recommended for removal by a majority vote of the region and a majority vote of the Executive Committee and the approval of the Director of the Division of Behavioral Health Services.

Section 10.01

In all procedural matters not governed by these Bylaws, the AMHPAC shall be bound by the provisions of Robert's Rules of Order (10th Edition).

Section 11.01

The Arkansas Mental Health Planning Advisory Council Governing Bylaws were presented and adopted this

22nd day of August 2007.

Section 12.01

APPROVED:	**APPROVED:**
This 22nd day of August 2007 .	This day of 2007
State Chair, Arkansas Mental Health Planning Advisory Council	Director of the Division of Behavioral Health Services

ARKANSAS MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

To: **Jay Bradford**
From: **Joyce Soularie**
Date: **August 23, 2007**
Subject: **AMHPAC Activities**

Memo

The last Fiscal Year has been an extremely busy year for the Arkansas Mental Health Planning and Advisory Council and we are pleased to share our activities with you.

In October 2006, the AMHPAC hosted a Legislative Forum. This was a two day event that was facilitated by Laurel Peterson and Lu Ann Southern of the National Mental Health Association. The first day was a time of educated our AMHPAC members, legislators and candidates. The second day, just for AMHPAC members was a time of brainstorming around issues that presented a challenge for consumers and families as they accessed services around the state. This 2 day event was attended by about 50 individuals (consumers, families and youth) each day. The highlight of this event was a Youth PowerPoint Presentation, these 7 youth from across the state talked about their experiences in the various child serving agencies.

Many AMHPAC members were present and/or testified at the various Legislative Committees that were working on mental health issues during the recent legislative session. Many of our members followed House Bill 2358 from the first draft to the actual signing of the Act 1593.

There have been 6 AMHPAC members working with the SOC committee and sub-committees this last year. Of those 4 were appointed to the Governor's Commission on Children's Behavioral Health Care. We are looking forward to the first meeting of the commission on the 30th of August.

There were also 3 members of AMHPAC involved in the 1st Lady's Listening tour. These family members were facilitating on transcribing each of the stops that Mrs. Beebe made.

The Chair of AMHPAC was voted in as Vice Chair of the Governor's Integrated Services Taskforce (GIST) and it is hoped that mental health issues will have greater visibility for this group in the future.

AMHPAC held its annual retreat again this year during Pre-Institute. This year our focus was on internal issues. We spend some time talking about what our federal mandate actually means, what we've done in the past to fulfill that charge and developing plans for the upcoming year. A highlight of Institute this year was the AMHPAC sponsored Youth Presentation (a continuation from our October meeting) titled "We know you hear, but are you listening?"

As you can see this has been a productive year for the AMHPAC and our goal is to continue our activities across the state in the upcoming year. Our focus over the next 12 months will be around stigma and discrimination issues and Consumer/Family Driven, Youth Guided and Child Centered.

Thank you for the opportunity to share our accomplishments with you. If you would like any clarification on any of our activities please feel free to contact us.

Arkansas

Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Description of Opportunity for Public Comment on Plan.

The primary forum for public comment on the State Plan is through the Arkansas Mental Health Planning Advisory Council. Additionally, a notice of the Plan's availability for review and comment is posted on DBHS's web site and in the state's largest circulation daily newspaper. The newspaper notice is as follows:

ARKANSAS' 2008 MENTAL HEALTH FEDERAL BLOCK GRANT
STATE PLAN AVAILABLE FOR PUBLIC COMMENT

Under the authority of the Public Health Service Act, the Secretary of the Department of Health and Human Services, through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), awards block grants to states to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness and children with serious emotional disturbances. States are required to submit an application for each fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State Plan contained in the application, to evaluate programs and services set in place under the Plan, and to conduct planning, administration and educational activities related to the provision of services under the Plan. The State Plan includes: 1) a description of the state service system; 2) identification and analysis of the service system's strengths, needs and priorities; and 3) performance goals and action plans to improve the service system.

Block Grant legislation stipulates that as a condition of the funding agreement for the grant, State's will provide opportunity for the public to comment on the State Plan. States will make the Plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the Plan (including any revisions) and after the submission of the Plan to the Secretary of the Department of Health and Human Services.

Arkansas' 2008 Mental Health Federal Block Grant Application State Plan will be available for review and comment in August, 2007. To receive an electronic version of the Plan, e-mail your request to kathy.waters@arkansas.gov To receive a printed version of the Plan, mail your request to Kathy Waters, Division of Behavioral Health Services, 4313 W. Markham Street, Little Rock, AR 72205. You may forward any comments on the Plan to Ms. Waters.

The 2008 Plan must be submitted to CMHS by September 4, 2007. A request of approval of a modification to the Plan may be made at any time during the year. Comments on the Plan may be made at any time during the year. Comments will be considered in formulating the 2008 plan and any modification of this plan, and/or in the formulation of the 2009 Plan.

Arkansas

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Adult
1. Overview of State's Mental Health System

The Division of Behavioral Health Services (DBHS) is Arkansas' Single State Agency for Mental Health. The Division of Behavioral Health Services is part of the Department Human Services (DHS), an umbrella agency that includes twelve other Divisions responsible for providing social, health and human services, including those for the developmentally disabled, the elderly, adjudicated youth, and at-risk children and families. Also within DHS is the state's Medicaid Authority agency, the Division of Medical Services. The Director of DHS is appointed by the governor and sits in the governor's cabinet. The Director of DHS, in turn, appoints the Director of DBHS.

Priority populations to be served by the public mental health system are: adjudicated individuals found not guilty by reason of mental disease or defect; individuals assessed as potentially violent; other forensic clients; adults with serious mental illness (SMI) and children/adolescents with serious emotional disturbance (SED). Additionally, to the extent that funds are available, others with mental health problems are eligible for the services of the public mental health system.

The Division of Behavioral Health Services discharges its responsibility for the provision of public mental health services by operating the 202 bed Arkansas State Hospital (ASH) and the 325 bed Arkansas Health Center skilled nursing facility, by contracting with fifteen local, private, non-profit Community Mental Health Centers (CMHCs), and certifying three private, non-profit specialty Community Mental Health Clinics. Additionally, DBHS provides training and research support for the system through the Research and Training Institute (RTI) operated in collaboration with the adjacent University of Arkansas for Medical Sciences (UAMS).

Effective July 1, 2003, the state's alcohol and drug abuse authority agency, Alcohol and Drug Abuse Prevention (ADAP), was moved from the state's Health Department to DHS and combined with the former Division of Mental Health Services to form the new Division of Behavioral Health Services. DBHS is, thus, now the single state agency for both public mental health services and public alcohol and drug abuse prevention and treatment services.

Arkansas

Adult - Summary of Areas Previously Identified by State as Needing Attention

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Adult
2. Summary of Areas Previously Identified by State as Needing Attention

Evidenced-Based Practices

As part of its system transformation activity, the previous three years' plans have noted the DBHS priority of beginning to move the system to greater availability of evidenced-based practices (EBP). Assertive Community Treatment (ACT) is the EBP that DBHS has had the longest standing and most direct financial role in supporting. DBHS funded the start-up and initial several years of operation of the state's first ACT program (GAIN). Over time, as has been the case with other elements of the public mental health system, GAIN moved to greater reliance on Medicaid for its funding. However, DBHS has continued to provide some state general revenue funding to GAIN to support the provision of ACT services for individuals without Medicaid, especially such individuals with multiple Arkansas State Hospital admissions. The level of funding to GAIN had remained constant over the past several years and with increased costs, the case rate was no longer adequately funding the services provided. DBHS increased its funding to GAIN to support an increased case rate beginning in SFY 2006.

The community providers in the public mental health system, Community Mental Health Centers and Clinics (CMHC), are all independent, private, non-profit organizations. Some of these CMHCs have undertaken the development of EBPs on their own initiative, without DBHS mandate or additional financial support, although with DBHS encouragement and technical support. In this manner, three additional ACT programs had been developed. However, DBHS was recently informed that due to high staff turnover rates and a consequent inability to maintain fidelity to the service model, one of these three programs has suspended operations. The director of this program has indicated to DBHS the intention of reopening this program when adequate staffing can be achieved.

As noted in previous years' plans, DBHS has undertaken to systematically survey the implementation status of all EBPs across the system and obtain a count of the number of CMHCs providing each EBP. DBHS has noted that there are significant definitional issues to be addressed in this data collection endeavor, in particular, with being able to specify a required level of model fidelity and being able to distinguish between programs providing EBPs versus aspects of some EBPs (such as Illness Management and Recovery) that have become part of routine clinical care. In the Special Services Program (SSP) report instituted for SFY 2006, the following number of CMHCs reported providing the following EBPs: Supported Employment (6), Supported Housing (6), Family Psychoeducation (4), Integrated Treatment of Co-Occurring Mental Illness and Substance Use Disorders (4), Illness Self Management (5) and Medication Management (1).

Local Acute Inpatient Care

As noted in previous years' Adult Plans, developing capacity and access for local acute inpatient care has been a significant problem facing the adult system of care. The origin of this problem

was described in previous years' plans. In response to the need for more acute care capacity, the state legislature appropriated $5.8 million for SFY 2004. DBHS initiated a local acute care program in November of 2003. Funding for this program was increased to $9.3 million for SFY 2005 and has been increased to $11,550,000 annually for SFY 2006 through SFY 2009. Funds are distributed to CMHCs on an adult per capita basis. During SFY 2007, this program paid for 2,796 admissions and 15,600 days of local inpatient care admissions. The average length of stay per admission was 5.3 days. CMHCs contract with local hospitals for this care and serve as the point of access to this service, and as the utilization managers of the benefit. The CMHCs also provide alternatives to inpatient care when this is possible, and provide the aftercare when those hospitalized are discharged.

A major problem encountered with the provision of local acute care is the uneven distribution of available general adult inpatient psychiatric beds. There is a concentration of beds in Central Arkansas and a relative shortage of beds in the Northwest part of the state which is the fastest growing and now has the highest population concentration. Through the work of local CMHCs and legislators, the 2007 State legislature appropriated $3.1(m) in one-time funding to support the expansion of bed capacity in Northwest Arkansas. DBHS has developed a plan that will potentially add 46 beds in that region of the state, and is now awaiting word on whether the appropriation will be fully funded.

Data System Improvements

Having data to adequately monitor the public mental health system's performance has been noted as a continuing challenge in the past several block grant applications. During the past year, significant progress has continued to be made in meeting this challenge. In the past, DBHS collected both client level data (Client Data File and Services Data File) and aggregate level data (Basic Services Program report) from its Community Mental Health Centers and Clinics. The client level data did not contain a unique identifier, so it was not possible to produce unduplicated counts of clients served. Also, for client level data, except for the basic demographic fields of race, gender, age and county of residence, the reliability of the data being collected had not been established, and there was no link between the client and services data fields. The aggregate data collected did provide information for tracking many aspects of the system's functioning, but also did not have unique client identifiers and did not permit breakdown of data into desired subcategories, such as the basic demographic areas just noted. Client satisfaction data was only available through the aggregate data collection system and the instruments used in the surveys varied among the CMHCs.

During the past several years, in part with funds provided through the Data Infrastructure Grants (DIG), DBHS has undertaken to substantially enhance its data collection systems. It has entered into a contract with a private vendor to collect, store and report system-wide client and service data. This effort has built on a data collection initiative independently developed through the CMHC's provider trade association, the Mental Health Council of Arkansas. This earlier initiative allowed DBHS to move ahead in developing an improved data system much quicker than would have otherwise been possible. The system operates through a secure encrypted web-based application. The system includes unique client identifiers which allow determination of unduplicated counts served, allow the linking of client data with service data, and enable the

tracking of clients across the system, including as they move from community care to treatment in the Arkansas State Hospital and vice-versa. Providers submitted test data files during the first half of calendar year 2005 and the system became operational July 1, 2005. With submission of data for June, 2007 (due by the end of July) the first full two years of data will have been collected. The new data system is supporting enhanced reporting in the Uniform Reporting System (URS).

Client Satisfaction Surveying has also been significantly improved over the aggregated, CMHC-specific system described above. DBHS contracted with a private vendor with extensive experience in conducting surveys of the state's Medicaid population to conduct a statewide uniform survey with a random sample of sufficient size to yield valid and reliable results. Four hundred returned scorable surveys from each population were required state-level reliable results at the 95% confidence level. With input from system stakeholders, DBHS decided to use the SAMHSA-recommended MHSIP adult and child/family surveys, with the addition to each of items of local interest. For the 2005 survey, a random sample of 1,600 adult clients and 1,600 child/family clients was drawn, yielding slightly over 1,300 valid addresses in each sample. A total of 597 adult surveys and 501 child surveys were received back. After eliminating surveys that were less than 80% complete and excluding otherwise disqualified surveys, 542 (40%) adult surveys and 479 (35%) child surveys were available for analysis. For the 2006 survey, the initial children's sample was increased to over 12,000 so as to be able to obtain results valid at the individual provider organization level. For 2006 there were 530 usable adult surveys and 3,486 children's surveys. The survey results (including for 2006, a list of CMHCs with scores significantly above or below the state average) have been made available to stakeholders in a number of formats, including a consumer-friendly "Report Card" and web-accessible reports.

Coordination with Medicaid

The significance of Medicaid funding for Arkansas' public mental health system has been noted extensively in previous block grant applications. Coordination with Medicaid will be a significant issue for DBHS into the foreseeable future. Medicaid provided approximately 57% of CMHCs' funding for SFY 2006, while funds administered through DBHS (state general revenue dollars and federal block grant funds) account for approximately 19% of their funding. The state's Medicaid Authority, the Division of Medical Services (DMS), is a sister Division of DBHS within the state's Department of Human Services (DHS). DBHS maintains ongoing contact with DMS to work through issues related to Medicaid funding of the public mental health system. DBHS' Assistant Director for Adult Services and Assistant Director for Children's Services each chair a Quality Improvement Committee that oversees the operation of the Medicaid contractor providing prior authorization of services under the state's rehab option plan, Rehabilitation Services for Persons with Mental Illness (RSPMI). Medicaid forwards to DBHS staff, for review and comment, all proposed policy and procedure changes in this RSPMI program. DBHS senior staff meets with Medicaid staff frequently to review and provide answers to provider questions regarding the application of these policies and procedures. A focus of mutual concern to DBHS and DMS is the rapidly increasing level of reimbursements under this program in the past few years. This increase has been occurring even with the prior authorization programs noted above.

Integration of Mental Health and Substance Abuse Treatment Services

As reported in previous block grant applications, the former Division of Mental Health Services (DMHS) and former office of Alcohol and Drug Abuse Prevention (ADAP) were merged into the Division of Behavioral Health Services (DBHS) effective July 1, 2003. Division level administrative staffs were co-located on October 1, 2003. Also, as noted in previous applications, the staffs from both Mental Health and ADAP worked together to submit a COSIG grant proposal for infrastructure development to provide integrated mental health and substance abuse services. DBHS was informed in the fall of 2003 that it had received this grant in the amount of $1.1 million per year for three years, with lesser amounts in years four and five. Implementation of this grant has been the primary vehicle though which initial steps are being taken to integrate the service delivery systems of these aspects of behavioral health care. The primary focus of the grant has been to implement system-wide screening for co-occurring disorders, with the goal being that all mental health (MH) providers will use a common instrument to screen for substance use disorders and all substance abuse (SA) treatment providers will use a common instrument to screen for mental health disorders. The grant has supported planning and training activities attended by both mental health and substance abuse providers. There have been some anecdotal reports of enhanced communication, referral and cooperation between SA and MH providers resulting from these joint activities. The original goal of the grant was only partially achieved. Twelve of the state's fifteen CMHCs have participated in the COSIG grant activities focused on implementing a common assessment instrument. However, DBHS has now added a contract requirement that, effective July 1, 2007, all CMHCs will conduct the COSIG screening for substance use disorders (or an approved alternative) for all adults admitted for service. DBHS has also completed the first test run of linking the MH and SA data system (each using SSN as common unique identifiers) so as to be able to track client movement between the systems.

Arkansas State Hospital

DBHS' Central Administrative Offices and the Arkansas State Hospital (ASH) sit adjacent to the University of Arkansas for Medical Sciences (UAMS) in Little Rock. DBHS entered into an agreement two years ago with UAMS to deed to it a portion of the grounds on which its facilities sit in exchange for UAMS having constructed for DBHS a new State Hospital facility. This will be part of a larger building project by UAMS to expand its teaching hospital and related facilities. The new State Hospital will have approximately the same number of beds as in the existing facility; however, it will be a new modern facility much better configured to support the hospital's active treatment model. Also, as a part of its expanded hospital, UAMS will open a 40 bed acute psychiatric inpatient unit. These beds will be an additional response to the above noted need for local acute care beds. Public local acute care funding for utilization of these beds will be through the established CMHC Single-Point-of-Entry screening process.

Arkansas

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Adult
3. New Developments and Issues

Local Acute Inpatient Care

As noted in other sections of this application, a major problem encountered with the provision of local acute care is the uneven distribution of available general adult inpatient psychiatric beds. There is a concentration of beds in Central Arkansas and a relative shortage of beds in the Northwest part of the state which is the fastest growing and now has the highest population concentration. Through the work of local CMHCs and legislators, the 2007 State legislature appropriated $3.1(m) in one-time funding to support the expansion of bed capacity in Northwest Arkansas. DBHS has developed a plan that will potentially add 46 beds in that region of the state, and is now awaiting word on whether the appropriation will be fully funded.

Medicaid

Ongoing developments in Medicaid, (the largest funding source for services in the state's public mental health system), continues to present issues that significantly affect the mental health system. Although the current primary focus of Medicaid reform is likely to remain on children's services, some changes initiated in that reform effort, such as certification procedures for providers and the addition and/or redefinition of service categories, also potentially affect the provision of services to adults.

Data System Enhancements

Planned enhancements to the DBHS' data system are ongoing. For SFY 2008, DBHS is continuing efforts to incorporate local adult acute inpatient care into its client level data reporting system. This effort, begun in SFY 2007, proved more challenging than originally anticipated, but it is now hoped that reliable data in this area will be produced for SFY 2008. For the 2007 client satisfaction survey, currently under way, DBHS is greatly expanding the size of the sample for its statewide MHSIP survey of adult services so that reliable and valid results can be reported at the individual provider organization level. A similarly expanded sample for children services was successfully executed in 2006. DBHS anticipates that these new data reporting enhancements will permit better monitoring of system performance, including revealing aspects of the system that could benefit from quality improvement initiatives. The new enhanced system will, in turn, allow tracking of the results of these initiatives.

De-Merger of the Department of Health and Department of Human Services

The last couple of State Plans have noted the merger, effective July 1, 2005, of the Department of Health into the Department of Human Services to form the new Department of Health and Human Services (DHHS). During this past legislative session the governor was authorized to de-merge the departments, and this became effective July 1, 2007. Prior to and after the merger

DBHS has had a good working relationships with the Department/Division of Health, as evidenced by the inclusion of DBHS-sponsored optional modules in the Health Department's annual Behavioral Risk Factor Surveillance System (BRFSS) survey. DBHS anticipates that a good working relationship with the Department of Health will continue even as it returns to its independent department status.

New Division Director

In February of this year a new Division Director was appointed to replace the previous Director who retired after serving in the position a little over four years. The new Director has an insurance industry business background and is a former state representative and state senator. In the state legislature he served for a number of years as the chair of the Public Health and Welfare Committee which provides legislative oversight of the Division of Behavioral Health. In that role he was a strong advocate for improving the public mental health system.

Arkansas

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Adult
4. Legislative Initiatives and Changes

The Arkansas State Legislature meets biennially in regular session January through approximately May of odd numbered years. The Legislature most recently met January through April, 2007.

A significant portion of the legislation of interest to DBHS was focused on the children's System of Care reform and this is addressed in the Children's section of this application. Legislative action related to the adult system focused on the Arkansas State Hospital (ASH), local inpatient psychiatric bed capacity, and the mental health needs of individuals incarcerated in jails.

In this last legislative session, ASH received a significant $3.5(m) increase in its annual operating budget. This increase was necessary to offset previous year operating deficits which resulted primarily from increased costs of nursing services provided through agency staffing of the hospital and increased costs of medications. Legislation was also passed to provide special salary incentives to help ASH be able to recruit and retain nursing staff so as to be less dependent on agency nursing staff.

Through the work of local CMHCs and legislators, the 2007 State legislature appropriated $3.1(m) in one-time funding to support the expansion of local inpatient psychiatric bed capacity. DBHS studies had indicated an uneven distribution of available general adult inpatient psychiatric beds, with a concentration of beds in Central Arkansas and a relative shortage of beds in the Northwest part of the state which is the fastest growing and now has the highest population concentration. DBHS has developed a plan that will potentially add 46 beds in that region of the state, and is now awaiting word on whether the legislative appropriation will be fully funded.

Prior to the last legislative session, DBHS participated in a taskforce involving representatives of various aspects of criminal justice to address the mental health needs of persons incarcerated in local jails. This taskforce presented various proposals to the legislature but none were funded. However, the work of this group did help DBHS secure the above noted appropriation to expand local acute inpatient psychiatric beds which, in part, will meet the needs of jailed persons for acute inpatient psychiatric care.

Arkansas

Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System- Adult
5. Description of Regional Resources

Services are provided statewide through contractual relationships between DBHS and 15 certified community mental health centers (CMHCs) situated throughout the state. All of these CMHCs are private, non-profit organizations with local Boards of Directors. All CMHCs are accredited by either CARF or JCAHO. Each CMHC serves a designated geographic catchment area, and the CMHCs have service sites in 69 of the state's 75 counties. The CMHCs provide a range of services, which are described in detail under various criteria in the State's Plan. In SFY 2006, these CMHCs served 66,545 mental health clients, of which 45,232 were adults and 21,313 where children.

The CMHCs are the single-point-of-entry to the public mental health system. Once admitted to the system, the CMHC is responsible for providing and coordinating ongoing treatment. Entry into the Arkansas State Hospital or to state-funded local inpatient care is also through the CMHC, and the CMHCs are responsible for providing aftercare when these individuals are discharged from the hospital.

In addition to the 15 CMHCs, DBHS also certifies three specialty Community Mental Health Clinics. The clinics are all private, non-profit organizations, and are accredited by either CARF or JCAHO. These specialty clinics provide programs for persons with severe and persistent mental illness who require intensive levels of service. These clinics accept referrals from throughout the state, including from the CMHCs.

In addition to the state's Mental Health Centers and Clinics, DBHS also certifies private providers (both non-profit and for-profit) as eligible to contract with Medicaid to provide services under the state's rehab option. DBHS does not contract with or provide direct funding to these private providers; but, working with Medicaid, is becoming more involved in assuring quality of services from this provider group.

Arkansas

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

2008Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System- Adult
6. Description of State Agency's Leadership

DBHS' formal leadership role is exercised through its participation in the executive functions of state government, particularly within the Department of Human Services (DHS). Within DHS, and through DHS to the governor's office, the Director and other senior staff of DBHS advocate for the needs of the public mental health system. This includes both policy and budget advocacy. This advocacy is carried out in both regularly scheduled and ad-hoc meetings of DBHS senior staff with the leadership of DHS, and occasionally meetings with the staff of the governor's office. There are also frequent meetings, particularly on budget and personnel matters, with other executive departments of state government such as the Department of Finance and Administration.

Within DHS, DBHS staff is active in advocating for the public mental health system and bringing its expertise to the table with other DHS Divisions, such as the Division of Developmental Disabilities, Division of Children Family Services, Division of Youth Services and Division of Adult and Aging Services. Staff of DBHS meet frequently with staff of these other DHS Divisions involved with providing public human services, many of which have mental health components.

The most important DHS Division with which DBHS works is the Division of Medical Services (DMS), the state's Medicaid agency. As noted elsewhere, more funding of public mental health services actually flows through DMS than through DBHS. DBHS has developed a good working relationship with DMS. Senior staff of the two Divisions meet regularly, with several meetings a week not being uncommon.

DBHS also involves itself with other Departments of state government when issues of public mental health services are on the table. The Departments with which DBHS is most frequently involved include the Department of Education (which includes the state's Division of Vocational Rehabilitation Services), Department of Correction, and the Arkansas Development Finance Authority (housing).

In addition to its formal role of leadership on public mental health issues within state government, DBHS meets, consults and allies itself with other organizations to advance the cause of public mental health. This includes involvement with the Arkansas Mental Health Planning and Advisory Council (AMHPAC), the Mental Health Council of Arkansas (the CMHCs trade association), the University of Arkansas for Medical Sciences (especially its Department of Psychiatry), NAMI-Arkansas and the Arkansas Hospital Association.

Arkansas

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Child
1. Overview of State's Mental Health System

The State of Arkansas' mental health authority is the Division of Behavioral Health Services (DBHS). DBHS is part of the Department of Human Services (DHS), an umbrella agency that includes ten other Divisions responsible for providing health, social and human services, including those for the developmentally disabled, the elderly, adjudicated youth, and at-risk children and families. Also within DHS is the state's Medicaid Authority Agency, the Division of Medical Services. The Director of DHS is appointed by the Governor and sits in the Governor's cabinet. The Director of DHS, in turn, appoints the Director of DBHS.

Priority populations to be served by the system are: individuals found not guilty by reason of mental disease or defect; individuals assessed as potentially violent; other forensic clients; adults with serious mental illness (SMI) and children/adolescents with serious emotional disturbance (SED). Additionally, to the extent that funds are available, others with mental health problems are eligible for the services of the public mental health system.

The Division of Behavioral Health Services discharges its responsibility for the provision of public mental health services by operating the 202 bed Arkansas State Hospital (ASH) and the 325 bed Arkansas Health Center skilled nursing facility, by contracting with fifteen local, private non-profit Community Mental Health Centers (CMHCs), and certifying (and partially funding) three private, non-profit specialty Community Mental Health Clinics. The Arkansas State Hospital has a sixteen bed acute and residential unit for adolescents and a sixteen bed adolescent sex offender unit. In addition, DBHS provides training and research support for the system through the Research and Training Institute (RTI) operated in collaboration with the adjacent University of Arkansas for Medical Sciences (UAMS).

DBHS is the single state agency for both public mental health services and public alcohol and drug abuse prevention and treatment services.

The Department of Health became a division of the Department of Human Services in 2005, and the Department name changed to the Department of Health and Human Services (DHHS).
On July 1, 2007, the Division of Health Services was "de-merged" from the Department of Health and Human Services, and the names were changed again to the Department of Health and the Department of Human Services.

Arkansas

Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Child
2. Summary of Areas Previously Identified by State as Needing Attention

System of Care

Previous Block Grant Applications have identified that Arkansas has a fragmented system of behavioral health that needs significant reform. DHS has committed to the development of a statewide Comprehensive System of Care for children and families in Arkansas with mental health needs. A System of Care is described as being built upon a foundation of shared commitment by all relevant stakeholders (e.g., children, caregivers, service providers, advocates, judges, community members, etc.) to effective, community-based care for children with identifiable and treatable emotional disturbances. A System of Care functions to keep children with such challenging needs in their home, school, and community, guided by the caregivers to ensure safety for everyone, including the child, family and all community members. This project will be reported on in more specific terms in Section I.3.
The CASSP Coordinating Council elected to focus on System of Care activities for the past year. The CASSP Council Strategic Plan for 2006-2007 identified as priorities:

1. Build family support
2. Expand local capacity to collaboratively meet children's needs
3. Improve the quality of care
4. Public policy to positively impact children's mental health services

The Council worked diligently with DHS administrators and other System of Care stakeholders during the 2007 Legislative Session to pass a bill, Act 1593, to establish the principles of a System of Care for behavioral health care services for children and youth as the public policy of the State; for improving the effectiveness of behavioral health and related services to children, youth and their families. Other areas identified:

- The DHS Division of Child Care and Early Childhood Education (DCCECE) and the Arkansas Head Start State Collaborative Office continue to work with DBHS on an initiative that implements evidence-based prevention, early intervention and treatment services for young children, birth to eight years of age. DCCECE has again funded three pilot projects that provides early childhood mental health consultation by CMHCs for licensed childcare programs.
- DBHS has a contract performance indicator for the CMHCs to appoint an early childhood liaison. Each of the CMHC's has clinicians trained in assessment and treatment of the young child and consultation with child care providers. Program evaluation results suggest that there is some evidence that the project is having a positive impact on teachers' capacity to prevent and manage mental health problems in young children. This collaborative endeavor has been an important partnership that will strengthen the public mental health system.
- School-based mental health services are another focus for DBHS. All community mental health centers provide school-linked or school-based services. DBHS and the CMHC's are continuing to collaborate with schools and the Department of Education/Special Education in an effort to have a consistent approach in school-based mental health programs within the

Arkansas public school system. DBHS and the Department of Education combined funding to expand School-Based Mental Health Programs by CMHCs. Two of the grants were awarded a CMHC partnership with schools for special-needs populations, the School for the Deaf and the School for the Blind. Unfortunately the School for the Blind elected to withdraw from the grant process, but services for the identified students at the School for the Blind are available through the local CMHC, either clinic-based or at the school.

Data System Improvements

Having data to adequately monitor the public mental health system's performance has been noted as a continuing challenge in the past several block grant applications. During the past few years, significant progress has been made in meeting this challenge. In the past, DBHS collected both client level data (Client Data File and Services Data File) and aggregate level data (Basic Services Program Report) from its Community Mental Health Centers and Clinics. The client level data did not contain a unique identifier, so it was not possible to produce unduplicated counts of clients served. Also, for client level data, except for the basic demographic fields of race, gender, age and county of residence, the reliability of the data being collected had not been established, and there was no link between the client and services data fields. The aggregate data collected did provide information for tracking many aspects of the system's functioning, but also did not have unique client identifiers and did not permit breakdown of data into desired subcategories, such as the basic demographic areas just noted. Client satisfaction data was only available through the aggregate data collection system and the instruments used in the surveys varied among the CMHCs. Previously, the children's data was not collected through the Basic Services Program Report for use in the Block Grant, and only CASSP services data was collected through the CMHCs.

During the past several years, in part with funds provided through the Data Infrastructure Grant (DIG), DBHS has undertaken to substantially enhance its data collection systems. It has entered into a contract with a private vendor to collect, store and report system wide client and service data. This effort has built on a data collection initiative independently developed through the CMHC's provider trade association, the Mental Health Council of Arkansas. This earlier initiative allowed DBHS to move ahead in developing an improved data system much quicker than would have otherwise been possible. The system operates through a secure encrypted web-based application. The system includes unique client identifiers which allow determination of unduplicated counts served, allow the linking of client data with service data, and enables the tracking of clients across the system, including as they move from community care to treatment in the Arkansas State Hospital and vice-versa. Providers submitted test data files during the first half of calendar 2005 and the system became operational July 1, 2005. The first full year of data has been collected, and served as the basis for improved reporting for the 2006 Implementation Report.

Client Satisfaction Surveying has also been significantly improved over the aggregated, CMHC-specific system described above. DBHS contracted with a private vendor with extensive experience in conducting surveys of the state's Medicaid population to conduct a statewide uniform survey with a random sample of sufficient size to yield valid and reliable results. For the 2006 survey, the initial children's sample was over 12,000, so as to be able to obtain results valid

at the individual provider organization level. For 2006 there were responses on 3,486 children's surveys. The survey results have been made available to stakeholders in a number of formats, including a consumer friendly "Report Card" and web-accessible reports.

Medicaid Utilization Management

As in the previous Children's Services Plan, monitoring Medicaid-funded mental health services for the under-twenty-one population has continued to be an important issue for the children's mental health system of care. DBHS works closely with the Division of Medical Services (DMS) and the Medicaid utilization management company, APS Healthcare, to advocate for system changes to improve accessibility, availability and accountability of outpatient services for the Medicaid population.

DBHS and DMS included a component to the utilization management contract to provide "Care Coordination" to assist in transitioning children from inpatient services to community-based services. The DMS contract for SFY 2006 increased the level of care coordination for Medicaid eligible children. The purpose of Care Coordination is to assure that services occur in the least restrictive setting and contain an appropriate array of community-based services at the necessary level of intensity. Care Coordinators follow children that fall into "outlier" categories of children, who have received inpatient services. Examples of these categories include recipients under the age of six years, recipients that have had two or more hospitalizations in a year, and recipients with length of stay exceeding six months in residential treatment. Care Coordinators insure that children with serious emotional disturbance are referred to CASSP local service teams that are coordinated by each CMHC for multi-agency plans of service (MAPS).

APS will continue to provide data to DBHS on systems issues, services, gaps in service, and strengths and weaknesses in the mental health field. Issues that have been brought forth in the past year include the need for specialized services for the dually-diagnosed population (mental health/substance abuse and mental health/developmentally disabilities), better coordination and communication between inpatient and outpatient services, and the need for more intensive case management for children in the custody of DCFS.

The Division of Behavioral Health Services chaired a Quality Improvement Committee that met regularly to provide input to the State on Medicaid utilization management and other issues that impact the system of care. With the activities around System of Care development, the QIC members have broadened their focus and are actively engaged in System of Care reform through the Stakeholders Planning Committee and various workgroups. A Medicaid Workgroup was formed to review and develop recommendation in State Medicaid policy related to Children's Mental Health.

Arkansas

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Child
3. New Developments and Issues

In February of 2007, a new Division of Behavioral Health Services Director was appointed to replace the previous Director who retired in December 2006 after serving in the position for over four years. The new Director had served in the State Legislature for a number of years, and also was Chair of the Public Health and Welfare Committee which provides legislative oversight of the Division of Behavioral Health Services. In that role he was a strong advocate of improving the public mental health system.

Planned enhancements to the DBHS' data system are ongoing. DBHS will be greatly expanding the size of the sample for its statewide MHSIP survey of children's services so that reliable and valid results can be reported at the individual provider organization level. Also planned for SFY 2008 is upgrading on reporting of the provision of EBPs from an aggregate reporting system to the client level reporting system. DBHS anticipates that the data reporting systems will permit better monitoring of system performance, including revealing aspects of the system that could benefit from quality improvement initiatives. The enhanced system will, allow tracking of the results of these initiatives.

During the 2005 Legislative Session, Act 2209 was passed to create a Comprehensive Children's Behavioral Health System of Care Plan. A Children's Behavioral Health Plan Workgroup was formed to lay the ground work for development of a System of Care for children with mental health needs and their families. In February 2006, Cliff Davis, Human Services Collaborative, was hired as a consultant to provide Arkansas with an assessment of the current system and framework for systems development. His report was presented to the legislature in June 2006. A System of Care Stakeholders Planning Committee was established to assist DHS in this initiative. Members of the Committee include parents and family, youth, community collaborators, advocacy, state agencies and other resources. This committee was instrumental in the development of legislation addressing System of Care issues in the 2007 General Legislative Session. During the session, Act 1593 was passed to establish the principles of a System of Care for behavioral health care services. The Act also establishes these principles as the public policy of the State. The intent is also to ensure better utilization and coordination of the State's behavioral health care resources devoted to serving children, youth and their families. Families have expressed the need for more nontraditional wraparound services that include respite care, summer programs, and recreational programs.

The System of Care Stakeholders Planning Committee is moving forward by continuing to do work in subcommittees that will result in recommendations to a Children's Behavioral Health Care Commission that was appointed by the Governor in July, 2007. The Governor and his first lady have been active participants in the initiative to develop a System of Care that is family-driven, youth-guided and child-centered. Governor Beebe has held several press conferences and radio addresses on the System of Care initiative. Also, First Lady Ginger Beebe began a statewide "Listening Tour" in May 2007. She and other youth and family advocates have visited

with approximately 100 families who have children experiencing mental health issues, and have made contact with families in over 37 counties in the State.

The RSPMI Medicaid program funds the vast majority of mental health services for children. Lack of accountability in this program was cited in the report from Mr. Davis as being a major issue of concern. DBHS has made attempts to put more accountability measures in the system through proposing changes in the DBHS certification process that is required prior to a provider enrolling with Medicaid as an RSPMI provider. Unfortunately, those proposed changes have been blocked in legislative committees through efforts by a small number of private providers. DBHS continues to work with legislators, providers, family members and community stakeholders to implement more accountability measures. It is hoped that the Children's Behavioral Health Care Commission can assist in advising DHS and making recommendations that can influence the legislative process in adopting better accountability measures for the children's mental health system. The Stakeholder's Planning Committee has made the recommendation for the Commission to support the promulgation of revised rules for certifying RSPMI providers.

Arkansas

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Child
4. Legislative Initiatives and Changes

Legislative Initiatives

Act 2209 of 2005: An Act to Create the Comprehensive Children's Behavioral Health System of Care Plan. This law provided increased representation of private providers on the CASSP Coordinating Council. It also designated DBHS as the state agency responsible for the coordination and oversight of a Comprehensive Children's Behavioral Health System of Care Plan. All state agencies that receive funding, either state or federal, that supports behavioral health services, were mandated to participate in collaborative planning for the system of care. It required that in July, 2005, collaborative agreements were to be established between DBHS and all other state agencies regarding responsibilities for the development and implementation of the System of Care Plan. It also required that all agencies provide all pertinent information to DBHS, including expenditures and programming data that was necessary to develop the plan. As reported in Section I.3, this legislation has resulted in a DHS Departmental System of Care Initiative.

Act 1593 of 2007: A follow-up to Act 2209. This legislation establishes the principles of a System of Care for behavioral health care services for children and youth as the public policy of the State; for improving the effectiveness of behavioral health and related services to children, youth and their families, ensures better utilization and coordination of the States' behavioral health care resources devoted to serving children, youth and their families. The legislation also addresses the Children's Behavioral Health Care Commission that was established by the Governor to provide advice and guidance to the Department of Human Services and other state agencies providing behavioral health care services to children, youth and their families on the most effective methods for establishing a System of Care approach.

Senate Resolution (SR) 31: Requested a study of ways to improve the State's juvenile justice system for youth committed to the Division of Youth Services of the Department of Health and Human Services.

Act 643 of 2007: This act requested that the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth study the Juvenile Justice System regarding juveniles who have been committed to the Division of Youth Services or who are otherwise being detained in Juvenile Detention Centers.
The CASSP Coordinating Council has recently established a JDC/Mental Health committee to explore how mental health services are provided to the youth population confined in the 14 juvenile detention centers across the State. In most cases, youth are not receiving adequate services.

The federal Medicaid standard making children ineligible for service reimbursement upon entry into a correctional facility places the treatment burden on the shoulders of the counties. The counties tend to operate on a tight budget, often with little or no funding for the juvenile to

receive or continue treatment. Some manage better than others. The committee is comprised of detention facility directors, legislators, mental health providers, and Youth Services personnel. The goal of this committee is to make recommendations to the legislators on the Interim Study Committee, the Children's Behavioral Health Care Commission, and the CASSP Coordinating Council that could result in sweeping changes in the juvenile detention centers, and juvenile services as a whole. This endeavor has also led to better communication and collaboration with juvenile services personnel.

DBHS' enhanced data system went online July 1, 2005. It has been referenced and described in several other sections of this plan. This system permits better monitoring of system performance, including revealing aspects of the system that could benefit from quality improvement initiatives. The enhanced system will allow tracking of the results of these initiatives.

Arkansas

Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

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Part C. State Plan
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Services are provided statewide through contractual relationships between DBHS and 15 certified community mental health centers (CMHCs) situated throughout the state. All of these CMHCs are private non-profit organizations with local Boards of Directors. All CMHCs are accredited by either CARF or JCAHO. Each CMHC serves a designated geographic catchment area and have service sites in 69 of the state's 75 counties. The CMHCs provide a full range of services (as mandated by law), which are described in detail under various criteria in the State's Plan. In SFY 2006, these CMHCs served 66,545 mental health clients, of which 21,313 were children. The CMHCs are a point-of-entry into the public mental health system. Once admitted to the system, the CMHC maintains responsibility throughout the course of treatment. Entry into the Arkansas State Hospital or to state-funded local inpatient care is also through the CMHC, and the CMHCs provide aftercare when these individuals are discharged from the hospital.

The 15 CMHCs, are all private non-profit organizations, and are accredited by either CARF or JCAHO. These clinics provide programs for persons with severe and persistent mental illness who require intensive levels of service, and children and adolescents with a serious emotional disturbance, and others with mental health needs. Under the Medicaid Rehabilitation Option, (RSPMI), private providers are also certified by DBHS to provide outpatient services. They must be accredited by CARF, JCAHO or COA. Currently, there are 49 RSPMI providers, with CMHCs being 15 of those providers. The level and frequency of services provided by RSPMI providers varies widely from county to county, which is an area of significant concern. A Medicaid Workgroup under the System of Care Plan development is working on RSPMI regulation changes. Their goal is to improve services for children and families, know their effectiveness, and ensure services connect appropriately to communities.

Arkansas

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section I. Description of State Service System-Child
6. Description of State Agency's Leadership

DBHS Leadership Role

DBHS' formal leadership role is exercised through its participation in the executive functions of state government, particularly within the Department of Human Services. Within DHS, and through DHS to the Governor's office, the Director and other senior staff of DBHS advocate for the needs of the public mental health system. This includes both policy and budget advocacy. This advocacy is carried out in both regularly scheduled and ad hoc meetings of DBHS senior staff with the leadership of DHS, and occasionally meetings with the staff of the Governor's office. There are also frequent meetings, particularly on budget and personnel matters, with other executive departments of state government.

Within DHS, DBHS staff is active in advocating for the public mental health system and bringing its expertise to the table, with other DHS Divisions, such as the Division of Developmental Disabilities, Division of Children and Family Services and Division of Youth Services. Staff of DBHS meets frequently with staff of these other DHS Divisions involved with providing public human services, many of which have mental health components.

DBHS works closely with the Division of Medical Services (DMS), the state's Medicaid agency, and the Division of Children and Family Services. As noted elsewhere, more funding of public mental health services actually flows through DMS than through DBHS. DBHS has developed a good working relationship with both Divisions. The Directors of these Divisions are in frequent contact and their senior staff meets regularly, with several meetings a week not being uncommon.

DBHS also involves itself with other Departments of state government when issues of public mental health services and policy are on the table. The Department with which DBHS is most frequently involved on children's issues is the Department of Education.

Act 1593 of 2007 establishes the principles of a System of Care for behavioral health care services for children and youth as the public policy of the state. The Department of Human Services has taken the role of oversight for this important task which requires collaboration and data sharing by all other state agencies. The System of Care Stakeholders Planning Committee was chaired by a DHS Assistant Director. The DBHS Director is a voting member of the Stakeholder's Committee. The Children's Behavioral Health Care Commission, appointed by the Governor has taken over the functions of the Stakeholder's Committee. The DBHS Director and the DBHS Consumer Service Advocate were both appointed to the Commission. DBHS provides expertise and resources to the subcommittees that are currently working on making recommendations for system changes that should improve the effectiveness of behavioral health and related services to children, youth and their families.

In addition to its formal role of leadership on public mental health issues within state government, DBHS meets, consults, and allies itself with other organizations to advance the cause of public mental health. This includes close involvement with the Arkansas Mental Health Planning and Advisory Council (AMHPAC), the Mental Health Council of Arkansas (the CMHCs trade association), NAMI-Arkansas, Arkansas Federation of Families for Children's Mental Health, and Arkansas Advocates for Children and Families.

Arkansas

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities- Adult
1. Service System's Strength and Weaknesses

Comprehensive Community-Based System

The primary strength of the adult comprehensive community-based system of care is the existence of a well established, stable group of public mental health providers- the 15 CMHCs and three Mental Health Clinics. These 18 providers have all been serving their communities (CMHCs) or special populations (Clinics) for at least 15 years, and many have been providers for over 30 years. These providers, with local boards of directors, generally have high visibility in their communities and broad community support. From the point of view of clients, especially those with severe and persisting mental illness, the CMHCs and clinics provide for continuity of care over extended periods of time. All of the CMHCs provide the basic array of crisis intervention/stabilization, clinical and rehabilitative services (described in detail below).

The primary weakness in the adult comprehensive community-based system of care is that the breadth of services within the basic array varies among Centers; and, with some exceptions, evidenced-based practices (EBP) with known fidelity to the practice model are not in place. For example, all providers offer some type of intensive case management to clients with a history of extensive previous inpatient care and high risk of relapse; however, only three have established formal Assertive Community Treatment Programs intentionally following the EPB model. All providers offer 24-hour crisis intervention/stabilization of some type, but only four operate a residential crisis stabilization unit in which a client can reside overnight if needed. All providers offer some type of assistance with housing and employment. However, this varies from assessment and referral for services, to providers operating an extensive range of housing options or offering in-house staff dedicated to providing supported employment. All Centers provide services to the dually-diagnosed (mental health and substance abuse), but these range from coordinating services with a separate substance abuse provider to offering in-house integrated dual-diagnosis treatment.

As indicated in the "Transformation Efforts and Activities" portions of Section III below, DBHS is engaged in and promotes some transformation efforts, including some supportive of a Recovery-oriented system (for example, peer run support groups at ASH). However, as noted, this plan represents DBHS' first effort at a systematic review of activity in this area.

System Data Epidemiology

The state of Arkansas uses the federal definition to identify persons with a serious mental illness (SMI). A strength of the epidemiology data is that DBHS has developed an operational definition of serious mental illness and instituted a statewide, uniform physician certification procedure to identify those meeting the federal criteria. The use of this uniform procedure was phased in during the last quarter of SFY 2000. Since then providers have been reporting to

DBHS the number of individuals with a serious mental illness who are served that meet this definition.

Although the number with SMI served has been being reported, a weakness in the data system had been that this reporting did not have unique client identifiers that allow determinations of unduplicated numbers served. The reporting had been an aggregate report, rather than client level, and thus it was not possible to partial out subgroups of persons with a serious mental illness who are served on such criteria as gender, race or ethnicity. Recent developments in this area are described in sections below.

A weakness in Arkansas' epidemiology data is that, although DBHS is able to track penetration rates of numbers of persons with SMI served as a percent of the total federal estimated prevalence, the unmet need is not known, since it is not known how many individuals with SMI are being served outside the public sector.

Another specific gap in epidemiological knowledge, of particular interest to DBHS, is the level of unmet need for acute inpatient psychiatric services within the public mental health system, including in particular, among individuals incarcerated in local jails.

Rural and Homeless Populations

Being a rural state, Arkansas' public mental health system was developed to serve this population, and availability of services in rural areas generally is an overall strength of the system. Although becoming somewhat more urbanized, Arkansas continues to have a significant rural population. The state's CMHCs are disbursed around the state, frequently with headquarters in a rural community. Service sites are even more disbursed, being in 69 of the state's 75 counties. Even those few counties without a Center-operated service site, have services delivered there through off-site case management and other off-site programming such as services provided in local schools, human service agencies or correctional facilities. Some CMHCs also use an extensive transportation system to help reach the rural population. However, it is challenging to bring certain services to the rural population, especially those where efficiency depends, in part, upon economy of scale. This issue, for example, has presented barriers to extending Assertive Community Treatment in rural areas.

A strength of Arkansas' public mental health system is that a number of providers have housing programs, some quite extensive. To the extent these housing options are available, homelessness of at-risk individuals with serious mental illness can be averted. CMHC-controlled housing options are also available to individuals with serious mental illness who have become homeless. DBHS has a staff member that devotes a significant portion of her time to assisting CMHCs and other providers in developing housing options. Another strength of the system is the use of a competitive RFP process for distribution of PATH funds. This process, in part, depends on demonstrating need and helps focus the use of funds where they are most needed and will be most efficiently utilized. Although all services of the public mental health system are potentially available to homeless individuals with serious mental illness, it is a weakness of the system that access to these services is frequently problematic. CMHCs with PATH grants have dedicated

outreach efforts to the homeless. For all CMHCs, access of the homeless to services is frequently through its crisis intervention/stabilization program.

Management Systems (financing, staffing, training)

General revenues and other support to the public mental health system through DBHS have remained relatively stable for the past several years. This continuing level of general revenue support of the system is, in some senses, a strength, particularly in light of the significant reductions in funding of public mental health systems reported in some other states. As is the case nationwide, the public mental health system in Arkansas has grown increasingly dependent on Medicaid as its primary funding source. In SFY 2006, the Community Mental Health Centers and Clinics had revenues from Medicaid of approximately $118 million. This compares with approximately $40 million in revenue from DBHS-controlled funds, including the approximately $3.7 million federal block grant. Access to Medicaid funds is considered both a strength and weakness for the public mental health system. It has had the positive effect of greatly expanding the financial resources available to the system beyond what could have been possible depending on state general revenue funding distributed through DBHS. However, the system is also vulnerable to potential Medicaid funding shortfalls, and, to some extent, public mental health policy is more influenced by the state's Medicaid agency, the Division of Medical Services (DMS), than by DBHS.

There are anecdotal reports of significantly higher salary levels being paid in the for-profit sector attracting away staff from the public system, which presents the prospect of erosion of staff resources available for the public mental health system. However, the number of budgeted staff positions at CMHCs increased slightly for SFY 2007 to 3,141 from 3,041 budgeted for SFY 2006. This relative stability in the number of staff parallels the relative stability in the number of clients being served by CMHCs.

A significant strength of the public mental health system is the annual Behavioral Health Institute, of which DBHS is a major sponsor, including a $10,000 grant funding allocated from the federal block grant. This Institute has been held annually for the past 34 years and, in recent years, has drawn over 1,000 participants to a wide variety of training opportunities.

Arkansas

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

2008 Mental Health Block Grant Application - Arkansas
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2. Unmet Service Needs

Comprehensive Community-Based System

The service system need is that Evidence-Based Practices (EBP), and other practices supporting transformation and recovery, be more widely available throughout the service system. As noted in the section above, there is in place a statewide system of providers offering the basic array of services. However, the breadth of services within the basic array varies among Centers, and evidenced-based practices (EBP) with known fidelity to the practice model are not in place system-wide. The primary relevant data sources currently available to DBHS include an annual Resource Summary Report and a newly instituted semi-annual Special Services Program (SSP) Report from each of the state's CMHCs. The Resource Summary Report indicates the number of staff dedicated to providing various types of services (vocational, psychosocial day, day treatment, and case management) and the availability and service capacity of various types of programs (day treatment, psychosocial rehabilitation, crisis residential, and housing services). The SSP Report indicates the number of individuals provided the EBPs reported in the URS system.

System Data Epidemiology

The primary unmet need in the area of epidemiology data is for a measure of unmet service needs specific to the public mental health system. DBHS receives reports of the number with SMI served by the public mental health system providers and has access to the federal estimate of individuals in the state with SMI. From this data, public system service penetration rates are calculated. However, it is not known how many with SMI are in need of services during a specified time period, nor how many are receiving services outside the public system. A specific area of unknown need is that for acute inpatient services, particularly among those incarcerated in local jails.

Rural and Homeless Populations

Since Arkansas' system is largely rural, the unmet needs of the rural population largely parallel the unmet needs of the Comprehensive Community-Based System, as described above. Additionally, there are special challenges related to difficulties in achieving economies of scale in bringing certain EBPs and other promising practices to the rural population. DBHS identifies those living in counties outside a Standard Metropolitan Areas as being the rural population. Currently 63 of Arkansas' 75 counties are considered to be rural. DBHS' existing and newly implemented data systems include the identification of the county of residence of those served. This allows DBHS to track, within limits, the level of provision of services to the rural as compared with the urban population. The limit noted is that not all service categories of interest,

for example EBPs, are currently reported at the client level with linked designation of county of residence.

For the homeless population, the challenge is not just having the full array of services available, but also supporting and assuring access to these services, especially at Centers without PATH funding. As with rural residence, DBHS' data system also includes identification of the homeless status of clients served, although with the same limitation in the data system as noted above for the rural population.

Management Systems (financing, staffing, training)

The primary gaps in the management systems are an inability to track all dollars spent to specific services to specific clients, or even specific programs, and lack of a comprehensive accounting of staffing and training needs. The gap in knowledge of staffing and training needs results from the decentralized nature of the service system. As noted elsewhere, the system's community providers are all private non-profits with independent boards of directors. At this time, any system-wide understanding of staff and training needs is dependent upon ad-hoc reporting requests by DBHS. The gap identified in the financial management system results from the fact that most of the funds provided through DBHS are distributed to CMHCs as general program support grants. DBHS' funding support is contrasted to the funding provided through Medicaid which is reimbursed on a fee for service basis. DBHS' general program support model does have the advantage of giving providers considerable flexibility to design programs responsive to local circumstances. It is also relatively inexpensive to administer. Moving DBHS funding to a fee for service model, or even program specific funding, would entail added costs related to determining and processing client eligibility, and processing billing and payments. It would also likely require some type of utilization management system.

Arkansas

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities- Adult
3. Plans to Address Unmet Needs

Comprehensive Community-Based System

DBHS' initial efforts to promote wider dispersal of EBPs within the community-based system of care is to obtain and make public information on the current status of the provision of these services including the specific EBPs provided by each CMHC and the number of clients receiving these services. As noted elsewhere, this data had not been systematically collected before. DBHS collected data on the provision of EBPs during state fiscal year (SFY) 2006, and reported this data in the 2006 Implementation Report and in a new annual Special Services Program report that is distributed to all CMHC executive directors, Presidents of CMHC Boards of Directors and other stakeholders, including the Arkansas Mental Health Planning and Advisory Council (AMHPAC) and the state NAMI organization. DBHS is currently in the process of collecting data for SFY 2007 and this will afford the opportunity for a year to year comparison of any changes in the level of provision of EBPs. As others have noted, "what you count is what you get;" and, it has been DBHS' experience that, in some instances, merely counting and reporting a phenomenon can result in its increase. The data in the SSP report will also serve as the basis for planning for other systematic efforts to increase the availability of EBPs.

DBHS also plans to continue its efforts to promote the EBP of integrated treatment for co-occurring mental illness and substance use disorders. DBHS contracts with CMHCs now require, effective July 1, 2007, the use of the COSIG (or other DBHS approved) screening for all clients entering the public mental health system. DBHS has also tested its capacity to match its ADAP (substance abuse treatment) and mental health data sets to determine the numbers being concurrently served in both systems. DBHS plans to produce regular reports in this area in SFY 2008.

DBHS will also continue its informal encouragement and technical support to CMHCs wishing to implement EBPs on their own initiative. One area of particular technical support is consultation with CMHCs regarding billing components of various EBPs under Medicaid. DBHS will also continue the recently begun review with AMHPAC regarding the status of transformation and recovery oriented activities and priorities for advances in these areas.

While seeking to fill in service gaps as described above, it is also a priority of DBHS to maintain the current system of community care. A basic goal of this system is that inpatient psychiatric hospitalization be kept to a minimum. This goal is particularly supported by an assertive aftercare program for those being discharged from the Arkansas State Hospital (ASH) and an extensive case management system that includes taking the services to the client. In particular, DBHS will continue its focus on promoting prompt follow-up of clients being discharged from ASH to community care and to encourage provision of responsive case management for clients needing this service, in particular, taking this service out to the client in the community. The

social work departments of the Arkansas State Hospital will continue to be active in securing timely (at least within two weeks of discharge) follow-up appointments at CMHCs. DBHS also plans, with its new client level data system that integrates data reporting from both ASH and CMHCs, to begin tracking the rate at which aftercare appointments are actually kept. This information should serve as a useful basis for planning interventions to increase the rate at which aftercare appointments are kept. Responsiveness of case management will continue to be monitored by comparing the percentage of case management units provided "off-site" from the providers' facilities.

System Data Epidemiology

DBHS continues the process of enhancing its data systems, which will yield improved epidemiology data. The addition of a system-wide unique client identifier allowed, for the first time for SFY 2006, the determination of the unduplicated number of individuals with SMI served across the system. The previous aggregate data systems did not permit determination of an unduplicated count. The new client level data reporting also allows a more detailed look at the SMI population served in terms of demographic and diagnostic characteristics. DBHS will soon have available SFY 2007 data and this will permit, for the first time, a year over year comparison, within the new data system. DBHS is also modifying its monthly Local Acute Care report to capture the level of unmet need for acute inpatient psychiatric care, particularly among those incarcerated in local jails.

DBHS is also working with the Division of Health to obtain behavioral health population data through the annual Behavioral Risk Factor Surveillance System (BRFSS). The Division of Health included the optional anxiety/depression module in the 2006 survey and is including the optional module on serious mental illness and stigma in the currently on going 2007 BRFSS.

Rural and Homeless Populations

As previously noted, most of Arkansas' public mental health system is rural (63 of 75 counties) and the plans described above for responding to unmet system needs and other priorities apply to serving the rural population. DBHS plans to continue to monitor, as one its block grant indicators, the rate of delivery of service to the rural population as compared to the rate of service to those living in urban areas. The rural population does present special challenges in bringing to it certain EBPs and other promising and exemplary practices. These challenges include difficulties in achieving economies of scale and in distances clients must travel to receive services. DBHS has made efforts to persuade Medicaid to pay for services provided while transporting a client (as contrasted to paying for transporting a client, which is paid for by Medicaid under a separate program). Although these efforts have thus far been unsuccessful, DBHS will continue to push this point with Medicaid as the opportunity presents itself.

As previously noted, the primary issue with service to the homeless is access. Five of the state's fifteen CMHCs have PATH funding through DBHS which supports outreach to the homeless population. DBHS would like to increase the number of Centers with PATH funding and will continue to work with other smaller states to obtain an increase in its PATH funding.

Management Systems (financing, staffing, training)

DBHS' primary financing priority is to maintain its general state revenue system funding, including the percent of funds devoted to community services. Although the current biennium (SFY 08-09) just began, preliminary work on the next biennium (SFY 10-11) will begin in the next six months.

DBHS plans to begin exploring options for tracking more closely the expenditure of the funds it provides to CMHCs now as general program support grants. This, in part, will be accomplished with DBHS' new enhanced client level data system. This system includes a "first payor billed" field for each client service delivered. However, since "First Payor Billed" is not always the final payor for a service, DBHS will still not have complete client/service level accounting for funds, but will be able to take a significant step beyond its current tracking of CMHC finances. There has also been preliminary discussion regarding the possibility of converting some of the current general program support into come categorical, program specific funding.

Arkansas

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

2008Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities-Adult
4. Recent Significant Achievements

Comprehensive Community-Based System

Under its COSIG grant, DBHS has had some success with establishing infrastructure to support the provision of integrated treatment for co-occurring mental illness and substance use disorders. Providers of both mental health and substance abuse treatment services have been brought together in several training sessions related to treatment of co-occurring disorders. This has enhanced communication among these provider groups and there are some reports of improved coordination, if not integration, of treatment efforts. The state has adopted a uniform screening instrument to be used by substance abuse providers to identify the presence of mental illness, and a comparable instrument to be used by mental health providers to identify the presence of substance use disorders. Twelve of the state's fifteen CMHCs and all three of the certified specialty clinics participated in staff training on the use of these instruments. Effective July 1, 2007, all CMHCs are now required to use the COSIG screening instrument or a DBHS approved alternative.

DBHS initiated a new Special Services Program (SSP) aggregated data reporting system that, for the first time, systematically collects data on the provision of EBPs, including the number of clients at each Center receiving these services. DBHS incorporated the URS guidelines for reporting EBPs within its new reporting requirements. Data from this system was reported for SFY 2006 and the FY 2007 data report is currently being prepared.

System Data Epidemiology

DBHS initiated, as of July 1, 2005, a new data reporting system with system-wide unique client identifiers that has, for the first time, allowed determination of the unduplicated number of adults served who have a Seriously Mentally Illness. This client level data system also allows determination of the demographic and diagnostic characteristics of this population.

DBHS has entered into a partnership with the Division of Health that has resulted in the inclusion of the optional module on anxiety and depression in the 2006 BRFSS survey, and the optional module on serious mental illness and related stigma in the currently ongoing 2007 survey.

Rural and Homeless Populations

The Arkansas State Hospital has established with the local Social Security Administration an expedited review process, so that persons being discharged from ASH will have immediately available benefits, which in part can be used to secure housing, thus averting homelessness. After procedures have been refined this process will be extended to the local CMHCs.

The last legislative session established the Arkansas Legislative Taskforce to Study the Homeless. DBHS has a representative appointed to this taskforce.

Management Systems (financing, staffing, training)

As noted in previous block grant applications, DBHS received increased funding each of the past two bienniums for the Local Acute Inpatient Program. Funds in this program not only support hospitalization in local, non-State Hospital beds, but to the extent that savings are achieved in the use of these funds for inpatient care, these "saved funds" are utilized to enhance alternatives to inpatient care, thus potentially reducing the need for inpatient care and resulting in further savings to be applied to alternative care (a "virtuous cycle"). In the most recent legislative session, DBHS received a $3.1(m) appropriation to support the expansion of local psychiatric inpatient bed capacity in the under-resourced northwest region of the state.

Arkansas

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities- Adult
5. State's Vision for the Future

Comprehensive Community-Based System

The ideal comprehensive community-based system of the future is one in which Evidenced Based Practices and other practices supporting transformation and a recovery orientation are all available to all who would benefit from them. DBHS believes that the development of such a system will be a "work in progress" for the foreseeable future. Although the full array of desired services may never be universally available throughout the system, DBHS believes that steady movement of the system in this direction is a realistically achievable goal for the system.

Three other significant hallmarks of the desired future system are that:

- Practices are driven by demonstrated outcomes for consumers.
- Services are consumer-driven and provided in response to consumer choice.
- Services are not just potentially available, but their availability be widely known and accessible in a consumer-friendly manner.

System Data Epidemiology

The epidemiology data of an ideal system to serve the seriously mentally ill would include not just an accounting of the unduplicated number of these individuals served and a prevalence estimate of the number in the state needing services, but an estimate of the number needing services from the public mental health system and the types of services needed.

Rural and Homeless Populations

The ideal system for both the rural and homeless population is the same as the vision articulated above for the entire comprehensive community-based system of care. Given the rural nature of Arkansas' system and long standing commitment to and experience in serving this population, DBHS believes that the steady, but possibly slow, progress that it envisions for the entire system will be realized for the rural segment of the system.

Compared to the rural population, DBHS views bringing the full array of services to the homeless population as more challenging. Achieving this will require assertive outreach to this population.

Management Systems (financing, staffing, training)

Compared to the ideal future comprehensive service system, the ideal financial management system of the future is less clear. In this regard, two major issues are presented. One is the issue

of local autonomy and control versus the ability to track dollars to a specific service to a specific client. A second major issue is the relationship of DBHS to the Medicaid system.

DBHS does envision ways of combining both local autonomy with closer tracking of expenditure of funds, but this would entail significant expense to manage. Thus, a cost benefit analysis of different options will be needed. Initial discussion in this area are now planned.

With regard to Medicaid, DBHS clearly wishes to have maximum input into the Medicaid program to the extent that this involves policy driving provision of services in the public mental health system. The extreme of this would be DBHS managing the behavioral health Medicaid Benefit. This possibility has been considered off and on over the past several years and is still a matter of consideration and discussion.

Arkansas

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities-Child
1. Strengths and Weaknesses

Comprehensive Community-Based System

There are currently three operational programs that are considered as a wraparound, team-based process that implements individualized service and support plans for children with serious behavioral problems and their families. These programs operate under the Department of Human Services. One program is a System of Care grant initiative with federal funding from SAMHSA, and oversight by DBHS. All three systems require youth/family involvement.

Child and Adolescent Service System Program (CASSP)

- The CASSP Coordinating Council has identified goals to increase consistency and quality in the CASSP process on a statewide basis for Service Teams, Regional Planning Teams and the Coordinating Council. These goals will help to ensure that the CASSP process functions according to legislation, and that the Division of Behavioral Health Services, as the coordinating agency, increases accountability and support for CASSP on a statewide basis.
- The CASSP Coordinating Council has recently verified appointments and re-appointments of 48 positions for the 2007-2008 state fiscal years. The Directors of the Departments of Human Services, Health and Education make these appointments. Revised CASSP legislation has increased the involvement of a wide array of stakeholders in children's mental health issues including more participation in the public system of the private providers who provide RSPMI services, family members and youth. These changes have also increased the quality of the Council's actions. The Council Legislative Workgroup was very active in helping to pass System of Care legislation during the 2007 Legislative Session.
- The Executive Committee continues to meet at least monthly to work on issues identified by the full Council, and has provided strong leadership and focus on issues that have recently impacted the children's mental health system. A goal for the last state fiscal year was to add more parent and family representation to the Council and CASSP local teams. Four parent/family members, a child/family advocate, a youth coordinator and a youth were added to the CASSP Council for SFY 2007-2008.
- The Coordinating Council publishes a CASSP Newsletter and Report Card to raise awareness about CASSP and current children's mental health issues in the state. This newsletter and report card are included as part of the quarterly report to the Children and Youth Subcommittee of the Arkansas Legislature.
- The CASSP Coordinating Council has led the effort to expand services aimed at early identification and treatment for the needs among younger children before those needs escalate to a level of "severe" disturbance. Three early childhood projects were again funded to encourage community mental health centers (CMHCs) to develop more expertise at working with young children. This effort has required the building of new collaborative

partnerships with several types of expertise such as pre-school and day care providers, Head Start programs, pediatricians, family physicians and other public health entities.

- School-based Services have been developed and expanded through partnerships between the community mental health centers and school districts with some funding from the Division of Behavioral Health Services. These initiatives have proven to have positive outcomes for the children and the schools involved. Some community mental health centers in collaboration with the Department of Education have also joined a network of providers to do evidence-based, school-based mental health services. SOC implementation goals include policy changes in school-based services that will result in greater accountability and consistency in the program. The Division of Behavioral Health Services has worked closely with the current utilization management system to improve services for the U-21 Medicaid population and insure that outcomes are consistent with the CASSP and SOC principles. Care Coordinators have been utilized in the community to work closely with each community mental health center to prevent children in need of services from falling through the cracks. Many of these children are referred for individualized staffings through the CASSP process.
- Case management has been utilized to help families and the system manage services for those children and families with the most complex, severe, and complicated service needs. Case managers are extremely important to the success of school-based and home-based services, especially in the most rural areas of the state.
    - The Division of Behavioral Health Services has worked closely with the Arkansas Medicaid Division to look at potential modifications to the Arkansas Medicaid State Plan to improve availability and access to services. A System of Care Medicaid Workgroup is currently functioning to look at these issues, and make policy changes to achieve this goal.
    - Several children's mental health bills were passed during the 2007 Legislative session. The most significant bill passed was Act 1593 which establishes the principles of a System of Care for behavioral health care services for children/ youth and their families as the public policy of the State. Through development of this system, better utilization and coordination of the State's Behavioral Health Care resources devoted to serving children, youth and their families should be implemented with the goal of addressing behavioral health services with the same urgency as physical health.
    - The current Governor and First Lady have taken a personal interest in mental health issues. The Governor has done several press conferences and radio addresses support the System of Care initiative. First Lady Beebe has met with approximately 100 youth and families over the State in a series of "Listening Tours" to find out the needs and concerns of parents/children with mental health issues.

Together We Can (TWC)

Together We Can is designed to integrate and coordinate child-specific services for the 0-18 or to 21 years of age if the youth is still receiving services from one of the participating agencies. The family-centered services support the family unit and are designed to prevent removal of the child from the community in which the child and family resides. The program is predicated on empowering the local team (child/family active participants) to determine the services required to support and enhance family preservation, reunification and functioning. The local teams work

with the family to produce a multi-agency plan of services (MAPS) to address the services currently received, resources previously pursued, and outcomes of the services. TWC can provide services in counties that apply to have the program in their area. In some counties, TWC and CASSP work together by holding joint meetings and staffings on children who meet the criteria for both programs. To date, 36 counties have applied to become a partner in this system. TWC will take referrals on children who have both emotional and physical challenges.

ACTION for Kids

ACTION for Kids is a System of Care children's initiative that is a federally funded cooperative agreement between DHS and SAMHSA. The program serves children and youth with serious emotional disturbance and their families who need an intense, integrated, wraparound approach to mental health. The program operates in 4 counties in the State's Delta region and is family-driven, youth guided and child-centered. Young people are engaged**,** encouraged and supported as equal partners in decision-making along with their families. Families act as collaborators, advisers and advocates. The SOC is using this program as a model to be replicated statewide.

A comprehensive assessment of the State's current system was completed by Cliff Davis, Consultant from the Human Service Collaborative in 2006.

Strengths Mr. Davis identified while assessing our current system included:

- The shared commitment of stakeholders to provide the best possible care to Arkansas children with mental health needs and their families
- The assembly of meaningful cross-system data about mental health services provided to children and their cost
- An opportunity to promote collaborative planning and implementation of a system of care with most agencies housed under the DHHS umbrella, and to set up a framework for an integrated, cross-system data management system.
- Many pilot programs have supported the development of specialized system of care services in areas of the state, including school-based, early childhood, day treatment, and therapeutic foster care services.
- Regional CASSP and Local Service Teams might provide an existing infrastructure upon which to build localized planning and development for the system of care.
- Arkansas was awarded a System of Care Grant through SAMHSA that is now in its second year. This is the first SOC grant awarded to Arkansas. The federal grant is through collaboration with DBHS, Mid-South Health Systems and Counseling Services of Eastern Arkansas. ACTION for Kids covers four counties. The main goals are to ensure meaningful family involvement, provide wraparound services with collaborative agencies, use practice models that are proven and evidence-based, provide culturally sensitive services, and develop a system of outcome evaluations that will prove the effectiveness of the new system.

Mr. Davis' assessment also identified areas of concern that must be addressed in order to build an effective system of care in Arkansas. These concerns included:

- Family advocacy and support are poorly developed at the State level and are invisible in most Arkansas communities. Very few parents are involved in system decision-making.
- Parents and caregivers of children receiving system services generally do not believe that service providers pay attention to their input about their children's needs.
- Children's mental health services are delivered in a scattered way in many public systems, including at least the education, behavioral health, child welfare, juvenile justice and developmental disability systems, but no entity holds oversight responsibilities crossing those systems' funding and regulatory boundaries. This absence of integrated oversight leads to fragmented management and delivery of mental health services to children and their families.
- Current operation of the RSPMI program lacks any viable accountability mechanisms.
- No entity or organization holds local responsibility to coordinate mental health care for a child with serious and complex needs.
- Meaningful data describing service system functioning are not readily available to the Legislature in its deliberative processes that impact the functioning of each child and family serving system.
- Numbers of Arkansas children and adolescents placed in acute inpatient or residential treatment beds for care are extremely high (compared to other states), and the reported average lengths of stay are extremely long (compared to best practice).
- RSPMI program was designed to support a broad array of services for children with serious emotional disturbances, but the program lacks requirements for the intensive community-based services known to be effective for this high-need population. The absence of intensive treatment options contributes to the high Arkansas utilization of bed-based care.

As a result of Cliff Davis' assessment, DHS leadership made a commitment to improving behavioral health services to youth and their families. The Arkansas System of Care Stakeholders Planning Committee was formed to work on the important task of making short and long-term recommendations to DHS and policy makers to develop a System of Care for children's behavioral health. Representatives of families and youth, community partners, service providers, and state agencies have been meeting monthly to carry out this important mission. This group was very instrumental in getting Act 1593 passed. Some of the key elements that came out of the legislation to move the system of care framework forward are:

- Requiring flexible funds to be found;
- Requiring the use of standardized assessment;
- Improving data collection for accountability;' and
- Requiring that SOC services are family/youth driven

SOC workgroups are currently meeting to work on the areas of concern that were highlighted in Mr. Davis' assessment.

Governor Mike Beebe supported the SOC legislation through radio addresses and press conferences. In addition, Arkansas' First Lady Ginger Beebe took on the challenge of a

statewide "listening tour" with families in the state who have children experiencing mental health issues. The first event was a Children's Mental Health Summit. Parent and youth who have been diagnosed with a mental illness were invited to attend meetings that were facilitated for families by families. These forums were used to reach out to families at lunches, brunches, potlucks and other events across Arkansas. The first lady and other stakeholders met with approximately 100 youth/families in 37 counties of the State. These events were sponsored by NAMI Arkansas and Arkansas Advocates for Children and Families, and were funded by DHS as a kickoff to building a statewide family network.

Cliff Davis, System of Care Consultant did mini-training sessions called "System if Care 101" in June 2007. These sessions were held in 7 regional areas of the State.

System Data Epidemiology

The state of Arkansas uses the federal definition to identify children and adolescents with SED. Strength of the data is that DBHS has developed an operational definition of serious emotional disturbance and a uniformed physician certification procedure that is used statewide to identify those meeting the federal criteria. Also, APS, under contract to manage mental health services, has gathered substantial and significant data describing recent historical usage of Medicaid-paid services.

Analysis of Medicaid service utilization indicates that more children in Arkansas are designated as SED, than what is expected according to national prevalence rates. Also, more children are being placed in inpatient and residential facilities than other states with equivalent child populations. This issue is being assessed currently, and should be addressed when the SOC Medicaid Workgroup completes their task. They are working on making modifications to the State Plan.

A weakness in the data system is that reporting has been an aggregate report, rather that client level, and thus it was not possible to partial out subgroups of persons with SED who are served under such criteria as gender, race or ethnicity.

On a statewide level, there is currently no statewide data management system in place, and no data set describing consumer and family satisfaction with their experiences in receiving services. However, this problem should also be addressed through one of SOC workgroups that are currently meeting.

Rural and Homeless

A weakness in the system is that many system of care services are in place somewhere within the State, but they are lacking adequate capacity and within uneven distribution across the State. There is also a lack of qualified professional staff, both in rural settings and for several types of

mental health specialties (e.g., child-trained psychiatrists). A lack of adequate transportation is always seen as a major barrier in rural areas.

Plans are to alleviate some of these barriers by promoting and developing telemedicine capacities in rural communities, building staff capacity where needed, and providing better access and availability of mental health services in rural communities.

Management Systems (financing, staffing, training)

A significant strength is the amount of training that is offered through different child-serving divisions, departments, agencies, and other organizations. The focus for SFY'06-'07 was on early childhood issues and the System of Care Plan. Also, the public mental health system has an annual Behavioral Health Institute, of which DBHS is a major sponsor. Grant funding for this conference is allocated from the federal block grant. This Institute has been held annually for the past 34 years, and draws approximately 1,000 participants.

DBHS hired 1.0 FTE mental health professional for Children's Services. This staff member will assist in the RSPMI Certification Process, and Quality Management as well as providing clinical technical assistance to community programs. There are also plans for DBHS to hire an additional four staff members to assist in the development of statewide System of Care activities. There is a need for increased care capacity for special populations, including at least foster care children; youth involved in the juvenile justice system; sexual offenders; and youth dually diagnosed with mental health needs and developmental disabilities, and mental health needs and substance abuse. The System of Care Planning activities bring all these disciplines to the table. As a result, more collaboration between divisions and other child-serving organizations is taking place. Some of these activities to reduce barriers to services are the tasks of several SOC Workgroups developed to address Cultural Competence, Medicaid Policy Changes, Substance Abuse, Family and Youth, Accountability and Governance and Finance.

Arkansas

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities-Child
2. Unmet Service Needs

As mentioned before, the unmet service needs and critical gaps within the current system have been discussed and analyzed through data collection from the community mental health centers, Arkansas Medicaid, and APS, the managed care company. These concerns were also identified in the assessment of the current system of care completed by a consultant hired to put together a System of Care Framework for DHS and other stakeholders to use to further develop and implement a Comprehensive System of Care Plan.

Comprehensive Community-Based System

The various SOC Workgroups will make recommendations to the Children's Behavioral Health Care Commission was be appointed by the Governor. These recommendations will address the weaknesses that have been described in previous block grant applications:

- Numbers of Arkansas children and adolescents placed in acute inpatient or residential treatment beds for care are "cycling" in and out of these placements as a consequence of inadequate outpatient services available in the communities and inadequate follow-up when children are released from bed-based care
- Transportation of children and families to service/provider agencies is challenging and unreliable, more so in the most rural areas
- Needs for increased care capacity for special populations, including at least: foster children; youth involved in the juvenile justice system; sexual offenders; and, youth dually diagnosed with mental health need/developmental disabilities, and mental health needs/substance abuse.
- Very few services are available to treat youth with substance use disorders
- The RSPMI program was designed to support a broad array of services for children with serious emotional disturbances, but the program lacks requirements for the intensive community-based services known to be effective for this high-need population.
- Arkansas has a growing population of persons from Hispanic cultures, but there are only a few bi-lingual mental health service providers among the publicly paid treatment agencies.
- Need to develop an outcomes based data system to support an improved system of tracking, accountability and decision-making

System Data Epidemiology

An integrated (across all child and family serving systems) data management system is not currently in place, and meaningful data describing service system functioning are not readily available to the Legislature in its deliberative processes that impact the functioning of each child and family serving system.

Rural and Homeless Populations

- Transportation of children and families to service/provider agencies is challenging and unreliable, more so in the most rural areas. A few CMHCs provide transportation for some adult and children's programs.
- There is a lack of qualified professional staff, both in rural settings and for several types of mental health specialties (e.g., child-trained psychiatrists).

Management Systems (financing, staffing, training)

- There is a lack of qualified professional staff, both in rural settings and for several types of mental health specialties (e.g., child-trained psychiatrists).
- Higher education institutions in Arkansas are not involved in a planned effort to prepare persons to work in a mental health system of care approach.
- The sharp funding division between inpatient and outpatient mental health services appears to contribute to problems in obtaining follow-up services in the community.
- Minimal funding exists to support non-traditional, informal, wraparound services and supports for children and their families.
- There are anecdotal reports of significantly higher salary levels being paid in the for-profit sector, and this is drawing staff away from the public system.

Arkansas

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities-Child
3. Plans to Address Unmet Needs

Comprehensive Community-Based System

Through a shared commitment to provide the best possible care to Arkansas' children and adolescents with mental health needs and their families, the plan is to begin building the foundation to develop a system of care. The strategy is to use priorities developed by an interagency workgroup to guide future planning. The priorities are:

- Build family support. Arkansas will build a foundation of family support and advocacy aimed specifically at issues related to successfully raising children with serious emotional disturbances.
- Expand local capacity to collaboratively meet children's needs. Arkansas will develop the local capacity of communities to collaboratively manage the care of all children with serious emotional disturbances across all child and family-serving systems, assuring that services are effective, outcomes are monitored, and managers are accountable to families and to taxpayers.
- Improve the quality of care. Arkansas will enact a broad Quality Improvement Program aimed at improving the effectiveness of the System of Care. Accountability measures will be designed and implemented to assure the effective and responsible use of public resources for the mental health care of children and their families. Accountability is twofold: the System of Care must demonstrate to children with serious emotional disturbances and those who care about them (parents, family, caregivers, and others) that it is providing effective care to those children; and the System of Care must show taxpayers that it is using limited public resources in the most effective and cost-effective way possible.
- DHS has made available approximately 1 million dollars for System of Care development
- DHS has applied for several federal grants that would be used to support System of Care development and other activities.

System Data Epidemiology

Arkansas already has data frameworks in place that may serve as the foundation for an integrated, cross-system data management system and, with most systems managed under the DHS umbrella, the building of an integrated MIS system is feasible.

Rural and Homeless Populations

The federally funded ACTION for Kids system of care children's initiative is operating in 4 of the most rural areas of the state. The plan is to replicate the positive outcomes of this project statewide. Another recommendation from the Stakeholders Committee is to consider including

"Long Distance Learning" Tele-Medicine and Tele-Conferencing for a more cost-effective way to reach workers and clients in rural areas of the state.

For the homeless population, there are great challenges in accessing mental health services. Only five of the CMHCs have PATH funding, and several of these programs have not served families, only adult individuals. CASSP has been used to provide services to some of the families who are accessing mental health services through the CMHCs.

Management Systems (financing, staffing, training)

Substantial funds are currently being spent to support mental health services for Arkansas children. The goal is to assure that those funds are purchasing appropriate and effective services.

ACTION for Kids, the SOC SAMHSA funded grant in Northeast Arkansas, has allowed staff for that project to participate in the required training curriculum through Webinars, training at the local level and attendance to national and regional conferences. Training has included wraparound process, family and youth involvement, social marketing, evaluation and outcomes, cultural and linguistic competence, collaborative processes, evidence based practices, financial sustainability and many other topics related to establishing a System of Care. The staff at the project site provided training and information to the SOC Stakeholder's Planning Committee. Plans will have to include workforce development in all these areas in order to make systemic change on a statewide basis.

Arkansas

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities-Child
4. Recent Significant Achievements

Comprehensive Community-Based System

During the 2005 Legislative Session, Act 2209 was passed to create a Comprehensive Children's Behavioral Health System of Care Plan. A Children's Behavioral Health Plan Workgroup was formed to lay the ground work for development of a system of care for children with mental health needs and their families.

- In July, 2005 Memorandums of Agreement were signed between DBHS and the Department of Education/Special Education and all DHHS Divisions that serve children. A workgroup was established to review and research programs, expenditures, strengths and needs of the current system of care.
- In November, 2005 Chris Koyanagi with the Bazelon Center for Mental Health Law met in Arkansas with DHHS Division Directors, Dept. of Education/Special Education Director, juvenile justice, legislators, parents and other stakeholders to provide an overview and guidance on the development process related to systems of care.
- In February 2006, Cliff Davis, Human Services Collaborative, was hired as a consultant to provide Arkansas with an assessment of the current system and framework for systems development.
- Cliff Davis' report was presented to the legislature in June 2006.
- A System of Care Stakeholders Planning Committee has been established to assist DHS in this initiative. Members of the Committee include parents and family, youth, community collaborators, advocacy, state agencies and other resources. This committee successfully worked to have SOC legislation passed in the 2007 General Legislative Session.
- Act 1593 establishes the principles of a system of care for behavioral health care services for children and youth as the public policy of the state.
- Governor and First Lady Beebe supported the legislation, and have actively given their support through radio addresses, press conferences and the "Listening Tour" in which First Lady Ginger Beebe visited with approximately 100 families/youth with serious emotional disturbances in 37 of the 75 counties in the state.
- A major emphasis will be placed on building family support and advocacy, and involving youth receiving mental health services in the decision-making processes within the mental health system.

System Data Epidemiology

- The Arkansas Children's Behavioral Health Plan Workgroup assembled meaningful cross-system data about mental health services provided to children and their cost.
- Arkansas already has data frameworks in place that may serve as the foundation for an integrated, cross-system data management system and, with most systems managed under the DHS umbrella, the building of an integrated MIS system is feasible.

Rural and Homeless Populations

The new data reporting system with system wide unique client identifiers will help to identify more accurate counts on the rural and homeless populations. Most of Arkansas' public mental health system is rural (63 of 75 counties). DBHS will continue to monitor issues of service delivery that make access and availability of mental health services very difficult. CASSP staff has participated in four of the five PATH site visits for SFY'07. Several of the CMHCs that have these grants report seeing more children and families in need of services this year. DBHS would like to increase the number of CMHCs receiving PATH funding.

Management Systems (financing, staffing, training)

Services are currently structured so that trained paraprofessionals can deliver certain mental health services, thus extending the potential pool of workers.

- Training was held for the participants of the System of Care-ACTION for Kids federally funded children's initiative in rural Arkansas.
- The Early Childhood pilot project has provided ongoing training for community mental health center early childhood liaisons and other mental health staff to improve mental health services for young children.
- Mini-training sessions were done by Cliff Davis, SOC Consultant during June. The sessions were held in 7 regional areas of the State.
- The annual Behavioral Health Institute held annually in August, featured a session on System of Care change and a panel workshop that features youth with emotional and behavioral disharmonies.

Arkansas

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities-Child
5. State's Vision for the Future

Comprehensive Community-Based System

DHS has taken the lead in the development of a System of Care Plan in response to Act 2009 of the 2005 Regular Session, and Act 1593 of the 2007 Regular Session. The System of Care should provide mental health services and supports to children with mental health needs and their families that are accessible at the local level, regardless of what system they go through to access services. The SOC Workgroups will make recommendations to the Children's Behavioral Health Care Commission appointed by the Governor.

The goal is to develop a System of Care for children's behavioral health in Arkansas that:

- Is family-driven, youth-guided and child-centered;
- To provide cultural and linguistic competency and compatibility of the workforce;
- Supports and purchases evidence-based services when possible;
- Offers the least restrictive care;
- Utilizes a team approach to treatment decisions across local providers, stakeholders, experts, to address service needs; and
- Promotes evidence-based standards that guide services and public expenditures.

Parents and caregivers should be viewed as experts about their children, and have final choice about the types and mix of services they receive. The System of Care should ensure that comprehensive mental health assessments are done, when indicated, before service planning processes identify child and family strengths and match flexible services and supports to those strengths to address child and family needs. Child and family feedback should be elicited and constantly used to adjust services and supports, aimed at maximizing positive outcomes for children.

System Data Epidemiology

- Develop a comprehensive outcomes monitoring system that will enable system managers and taxpayers to understand exactly what services and impact are being purchased by public funds.
- Develop an integrated management information system across all child and family serving systems.

Rural and Homeless Populations

Promote and develop telemedicine capacities in rural Arkansas communities; and explore and develop multi-cultural, bi-lingual treatment capacities, where appropriate to the population of children in need of mental health care.

Management Systems (financing, staffing, training)

- Develop statewide training in the system of care approach to care of children and families
- Develop standardized pre-service training for all staff entering the publicly-funded helping systems
- Train more mental health professionals regarding early childhood practices
- DBHS will be providing technical assistance and training to the community mental health centers on comprehensive guidelines that will insure more consistency for the CASSP teams throughout the state.

Arkansas

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 1: Comprehensive community-based mental health services
A. Establishment of System of Care

The public community mental health system in Arkansas is a statewide system of services, with service sites in 69 of Arkansas' 75 counties. In addition to providing services at its own sites, CMHCs provide services off-site in clients' homes, schools, community hospitals, jails and client job sites. In this manner, services are provided in all 75 of the state's counties. Services are provided through 15 comprehensive Community Mental Health Centers (CMHCs), and three Community Mental Health Clinics serving clients with special needs. In SFY 2006, this public community mental health system served 66,545 mental health clients of which 45,232 were adults. All providers are private not-for-profit agencies that provide services funded primarily through Medicaid and contracts funded by state general revenue. All have national accreditation through either CARF or JCAHO.

Each CMHC is responsible for providing the basic array of services described in the following section to the residents of its geographic catchment area. The CMHCs serve as the single-point-of-entry into the public mental health system, including, as needed, admission to the Arkansas State Hospital (ASH) and to local publicly financed acute inpatient care.

Arkansas

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 1: Comprehensive community-based mental health services
B. Available Services

Each CMHC is responsible for providing the basic array of services described below to the residents of its geographic catchment area. Although the services described below are potentially available to all residents of a CMHC's catchment area, there do remain a significant number of individuals who, for a variety of reasons, do not receive the needed services. These reasons include: not knowing about the availability of services, not recognizing a need for the service or not being willing to seek the service, access difficulties of the homeless as described elsewhere and funding limitations.

Health, Mental Health and Rehabilitation

Upon entry into the system, the client is assessed by a mental health professional who determines appropriateness for mental health services and, if determined to be needed, develops a treatment plan in conjunction with the client. Also, as described in more detail below, each client is screened for co-occurring substance use disorders. Each CMHC offers an array of clinical mental health services and psychosocial rehabilitative services. Each CMHC also screens for physical health problems of each client and provides needed physical health care directly or refers for such care as needed.

Clinical mental health services include the following: diagnostic assessment and treatment planning, psychological testing, medication management, individual psychotherapy, group psychotherapy, marital/family therapy and acute day treatment**.**

Psychosocial Rehabilitative Services include the following: community support needs assessment and development of a plan of care, case management services including both on-site and off-site intervention, crisis intervention and crisis stabilization, psychosocial rehabilitative day services, collateral intervention involving consultation with other caregivers and persons involved in the clients life, and other rehabilitative and support services described below.

Employment Services

All CMHCs provide vocational screening as a routine part of the assessment of all clients. CMHCs also refer to the state Vocational Rehabilitation Services and/or other employment service providers. Nine of the CMHCs are certified by Arkansas Rehabilitation Services as a vendor for providing supported employment services. However, the activity of some of these centers in actually providing this service is relatively low. DBHS has an interagency agreement with Arkansas Rehabilitation Services to promote supported employment services within the public mental health system by explicitly authorizing use of its funds to provide mental health support services to those who have received or are receiving supported employment services. A

few CMHCs also provide in-house work crew employment and sheltered workshop employment for clients.

Housing Services

The CMHCs offer housing supports ranging from unsupervised independent living to supervised living in group homes. Each CMHC designs its housing support to meet local needs. Support may include assistance with utility deposits, assistance with rent or purchasing basic necessities such as food or furniture. Several CMHCs have been very successful in obtaining Section 811 funds and/or rental vouchers. Five CMHCs are recipients of PATH grants.

Educational Services

Some CMHCs offer general educational services such as GED or literacy classes on-site through arrangements with the Department of Education or through their own staff as part of psychosocial rehabilitative day programs. Other services are accessed through a referral to local community programs offered by vocational technical colleges or other educational institutions.

Substance Abuse Services

As detailed below, the most frequent focus of substance abuse services by CMHCs is the provision of services for individuals with co-occurring mental health and substance abuse disorders. Additionally, eleven of the state's CMHCs are also licensed by the state's substance abuse treatment and prevention authority (ADAP) which itself was merged into DBHS as of July 1, 2003. These CMHCs provide an array of educational, outpatient treatment, residential treatment and detoxification substance abuse services. Those CMHCs that are not ADAP licensed providers refer to ADAP licensed providers in their community.

Medical and Dental Services

Medical services are provided both in-house by CMHC employed nurses and physicians and through referral to other community providers. In-house services focus particularly on ongoing monitoring of the physical health status of clients on psychotropic medications. A couple of CMHCs are also providers of community (physical) health services and, as such, provide a very broad array of physical health services in-house to its clients. For the large portion of CMHC clients with Medicaid, access to physical health care services is relatively easy. For persons without Medicaid or other third-party payment, access to these services is more difficult. Access to dental health services is particularly difficult since the state's Medicaid program does not cover dental services for adults. Case managers attempt to find free or reduced rate services for those without Medicaid and for dental services.

Support Services

Obtaining needed support services, including income support and the housing support described above, is one of the primary responsibilities of a client's case manager. See immediately below for a description of case management.

DBHS also encourages peer support services through a grant to NAMI-Arkansas, which sponsors peer-run support groups for both consumers and family members**.** CMHCs refer clients to these support groups for services. Peer run support groups are now also provided at the Arkansas State Hospital.

Case Management Services

Case management is the heart of the Community Support Program (CSP) service system that assists persons with severe and persistent mental illness to maintain themselves in the community. Case management is defined as assisting the client in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. Together with the client, the case manager plans, coordinates, monitors, adjusts, and advocates for services and supports to achieve the ultimate goal of independent community living. For SFY 2007, the public mental health system budgeted for 651 case managers (77 mental health professionals and 574 mental health paraprofessionals). Of these, 54 mental health professionals and 332 mental health paraprofessionals were providing services to adults with a severe and persisting mental illness. The DBHS requires that persons with a severe and persistent mental illness and children with serious emotional disturbance receive, on the average, a minimum of 2 fifteen-minute units of case management services per month.

Services for persons with co-occurring (substance abuse/mental health) disorders

All CMHCs provide services to individuals with co-occurring mental illness and substance abuse disorders. The assessment of substance abuse issues is a routine part of the screening, comprehensive assessment and treatment planning for all mental health clients. The comprehensiveness and level of integration of treatment services for those with co-occurring mental illness and substance abuse disorders varies among centers. A few centers with limited resources provide only limited in-house treatment with a focus on the substance abuse component of the client's presenting problems (typically including substance abuse issues as a part of individual therapy, group therapy and case management). These centers then refer out to and coordinate additional treatment with a substance abuse provider. Some centers provide integrated in-house treatment of co-occurring mental illness and substance abuse disorders. Some integrated services are provided by staff that is dually certified as mental health professionals and substance abuse counselors. Other centers have staff that are certified substance abuse counselors, and coordinate treatment being provided by these counselors with that being provided by the mental health professional staff. Many mental health professional staff, although not formally certified as substance abuse counselors, have continuing professional education in this area. Integrated services include Mentally Ill Chemically Abusing (MICA) groups, in-house AA and NA groups, and education groups for at-risk populations. Several centers offer comprehensive programs addressing the needs of those with co-occurring mental illness and substance abuse disorders. In addition to those integrated services described, these centers provide such services as detoxification, inpatient and intensive residential treatment programs, multi-family groups, and chemical free-living environments. In addition to providing mental health services and integrated mental health/substance abuse services, as noted above, ten of the CMHCs either have contracts with or are certified by the Alcohol and Drug Abuse

Prevention (ADAP) to provide services for persons with primary substance abuse disorders. As already noted, effective July 1, 2003 the state's substance abuse treatment authority agency (ADAP) was combined with the former DMHS to form the new Division of Behavioral Health Services. The integration of these two agencies at the state administrative level is now in process, and it is anticipated that the future will see a higher level of integration of services at the provider/recipient level. As described above, implementation of a COSIG grant has been the primary vehicle through which initial steps are being taken to integrate the service delivery systems of these aspects of behavioral health care. The primary focus of the grant has been to implement system-wide screening for co-occurring disorders with all mental health (MH) providers using a common instrument to screen for substance use disorders and all substance abuse (SA) treatment providers using a common instrument to screen for mental health disorders. The grant has supported planning and training activities attended by both mental health and substance abuse providers. There have been some reports of enhanced communication, referral and cooperation between SA and MH providers resulting from these joint activities. Tests have been run on linking the MH and SA data system (each using SSN as common unique identifiers) so as to be able to track client movement between the systems. Also, language has been incorporated into the Medicaid Provider's manual for the RSPMI program that clarifies that mental health treatment for those with co-occurring disorders will be paid for by Medicaid even though the state's Medicaid Plan does not cover treatment for substance use disorders themselves.

Other services leading to reduction of hospitalization

The ASH aftercare program and the local acute care program are two other services that contribute significantly to the reduction of hospitalization. Additionally, there are three specialty Mental Health Clinic programs focused on those with multiple previous hospitalizations and high risk of rehospitalization.

The ASH aftercare program is a coordinated effort between the social work staff of ASH and the CMHCs. Prior to discharge of patients from ASH, the social work department is in contact with a designated liaison at the CMHC in whose area the client will be residing post discharge. The ASH staff communicates the course of the client's treatment at ASH and coordinates the follow-up that will be needed. The CMHC is expected to provide an appointment for the client within two weeks of discharge from ASH. Coordinated and responsive follow-up leads to reduced risk of rehospitalization. As noted above, the newly initiated data system will track clients from treatment at ASH to community care which will allow tracking not just the number given appointments, but also the number of such appointments actually kept.

The local acute care program reduces hospitalization by providing for hospitalization in the client's community were coordination of care and follow-up is more easily accomplished than if the client is hospitalized at ASH. In one instance, the coordination of care is to the extent of the psychiatric staff of the CMHC directly managing the client's inpatient treatment. The local acute care program began in November of 2003. The average length of stay for local acute care stays averages about 5 days per episode, as compared to the 20+ days length of stay for an acute hospitalization at ASH. Some of this difference is possibly accounted for by a risk selection factor of who is referred to ASH rather than for local care, but likely some of the decrease in

length of stay is the product of better coordination of care made possible with hospitalization in the client's own community. Also supportive of reduced hospitalization is the provision in the local acute care program that funds not expended to pay for inpatient care can be spent on providing services to reduce the need for inpatient care. CMHCs have used this provision to fund additional crisis stabilization programming and to purchase medications for those in acute crisis.

Specialized Community Mental Health Clinic programs are programs for persons with a severe and persistent mental illness who require a more intensive level of service intervention. The programs offer psychiatric services, case management, supervised community housing, day treatment, job coaching, medication monitoring, transportation, assistance with finances, assistance with daily living skills, and 24 hour crisis intervention and emergency services. All specialized community programs are either CARF or JCAHO accredited. Specialized community clinics include:

Birch Tree Communities: Birch Tree Communities is a community-based residential program that offers specialized services to persons with a severe and persistent mental illness. Originally based on the Benton Services Center campus, the program has now expanded to a large portion of the state, with nine different service sites. Birch Tree has been instrumental in creating a community living environment for persons with mental illnesses that have, in the past, been very difficult to maintain in the community.

Small Group Therapy: Small Group Therapy has been in operation since 1964 and is based on the Fairweather model of group living and group decision-making. Although SGT added Assertive Community Treatment as a service component in SFY 2003, it discontinued this program during the past year because staff turnover made it impossible to maintain fidelity to the practice model. The director of the program has indicated the intention of reinstating the program in the future if circumstances permit.

GAIN Program: The GAIN program (Greater Assistance for Those in Need) is an assertive community treatment program located in Little Rock. The program places special emphasis on serving clients with multiple inpatient admissions or those for whom traditional services have not been adequate.

Closely related to efforts to reduce psychiatric hospitalization are efforts to reduce unnecessary nursing home placement of individuals with mental illness. Arkansas maintains a very active Preadmission Screening Resident Review (PASRR) program for Medicaid recipients seeking admission to a nursing home or presenting a mental status change while residing in a nursing home. A DBHS employee devotes approximately fifty percent of her time to doing level two PASRR reviews. In addition to determining the appropriateness of nursing home placement, the review determines if the individual needs any mental health services, either in the nursing home or in order to be able to be maintained in a less restrictive community setting. Individuals are referred to their local CMHC for any mental health services that are determined to be needed.

Arkansas

Adult - Transformation Efforts and Activities in the State in Criteria 1

Adult - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 1: Comprehensive community-based mental health services
C. Transformation Efforts and Activities

Although the Division of Behavioral Health Services (DBHS) has undertaken some initiatives in the adult system of care that further some of the transformation goals outlined in the New Freedom Commission (NFC) report, including those focused on developing a recovery oriented system, this 2008 Block Grant Application represents DBHS' first systematic review and documentation of these mental health system transformation efforts. This review is organized around the 19 recommendations subsumed under the six NFC goals. Most of these 19 recommendations focus primarily on the development of a comprehensive community-based mental health service system, and the efforts and activities on these recommendations are reviewed here, under Criterion 1. However, Recommendation 1.1 (related to reducing stigma) is addressed under Criterion 2; and, Recommendations 3.2 and 6.1 (related to improved access in rural areas) are addressed under criterion 4. (Note that recommendations 4.1 and 4.2 are related to children's services and are addressed in the children's portion of this application.)

Recommendation 1.2: Address mental health with the same urgency as physical health.

There is no current systematic effort supported by DBHS to promote mental health treatment for those with physical illnesses that are being adversely impacted by co-occurring mental illness. Within the public mental health system itself the impact of mental health on physical health (and vice versa) receives some attention through mandated accreditation standards (CARF or JCAHO) which require that all clients of the public mental health system be screened for physical health problems and referred for needed treatment. Also, one of the state's Community Mental Health Centers co-locates programs and staff with primary health care programs. In these settings, clients presenting with physical health problems are routinely screened for mental health problems and referred for in-house mental health services as needed.

DBHS is an active participant in an ongoing study of the effectiveness of interventions for those with schizophrenia focused on assisting them to manage their diabetes. Senior DBHS staff serve on the planning and implementation committee for this study. These staff assisted in developing the studies' evaluation and intervention protocols and assisted in recruiting CMHCs as partners in the project.

Recommendation 1.2 also focuses on including issues of critical importance for mental health service delivery as part of the national dialog on heath care reform, including ensuring that Medicaid offers beneficiaries options to effectively use the most up-to-date treatments. In this area, DBHS has maintained an ongoing working relationship with the state's Medicaid agency (a sister Division within DHS). DBHS has had some success in promoting the interpretation of Medicaid rules within the states rehab-option to allow providers to be able to successfully use Medicaid fee-for-service component billing to support the provision of the EBP of Assertive Community Treatment. To support the EBP of integrated treatment of co-occurring mental

illness and substance use disorders, DBHS was also successful in getting language into the Medicaid manual clarifying that Medicaid will pay for treatment of mental illness for those with co-occurring substance use disorder, even though it does not pay for treatment of substance use disorders.

Recommendations 2.1: Develop an individualized plan of care for every adult with a serious mental illness (and child with serious emotional disturbance).

State mental health standards and state-mandated accreditation standards (CARF or JCAHO) require individualized plans of care, guided by client preferences, for every adult with serious mental illness. Compliance with this standard is a significant focus during accreditation site visits and is also intensively monitored, for Medicaid clients, by the state's contracted utilization management organization. Corrective action plans in this area have been implemented by a number of CMHCs in response to accreditation findings. Results from the 2006 statewide adult MHSIP consumer survey, indicate that 56% of respondents "Agreed" or "Strongly Agreed" with the statement, "I, not staff, decided my treatment goals." These results indicate that there remains considerable room for improvement in the implementation of this standard of care. Additional areas for possible future improvement in this area include expanding the range of treatment options available for consumers to choose among and providing opportunities for control over important funding decisions affecting their treatment.

Recommendation 2.2: Involve consumers and families fully in orienting the mental health system toward recovery.

The majority of the membership and leadership of the Arkansas Mental Health Planning and Advisory Council (AMHPAC) is composed of consumers and families of consumers, and serves as a strong advocate for orienting the state's mental health system toward recovery. DBHS provides financial, technical and administrative support to this group. A senior DBHS staff member serves as a liaison to this group and other senior DBHS staff meets regularly with AMHPAC, including in a planned series of meetings focused on receiving input from this group on the preparation of the block grant application State Plan. DBHS also provides some financial support to NAMI-Arkansas, another organization which provides consumer and family advocacy for orienting the mental health system toward recovery. Additionally, a representative of AMHPAC serves on the Governing Board of the Arkansas State Hospital and, as required by State Standards, the board of directors of local CMHCs include consumer/family representation.

Another facet of consumer involvement is the utilization of consumers as service providers. DBHS has taken some initial steps in this area by employing consumers to run peer support groups at the Arkansas State Hospital (ASH). These groups are particularly focused on a recovery orientation and utilize a multiple perspectives approach that emphasizes helping people to think about and define what they want to do with their lives after they get out of the hospital. ASH is organizing a conference this fall with Sherry Mead, a noted consumer/author, on trauma informed care and the use of peers in interventions to address trauma related issues. Local CMHCs are being invited to send staff to this conference. ASH has also established a working relationship with the local VA hospital which has established a psychiatric fellowship that operates from a recovery perspective.

Recommendation 2.3: Align relevant Federal programs to improve access and accountability for mental health services.

Although the state, obviously, cannot directly align relevant federal programs, it can seek better operational alignment of federal programs at the state level even within existing federal guidelines and can seek greater alignment of its own state programs.

DBHS has undertaken several efforts to better align existing federal programs as they operate at the state level. DBHS' work with the existing state Medicaid program to support the provision of EBPs has been described in Recommendation 1.2 above. DBHS has recently been made aware of a current Department of Human Services effort to secure a "Money Follows the Client" Medicaid demonstration grant that could provide opportunities to better align needs and services for Medicaid mental health clients. DBHS staff and staff of the Arkansas State Hospital (ASH) is working with the local Social Security Administrative staff to develop an expedited process of restoring benefits for individual returning to the community from ASH. DBHS's PATH grant coordinator is actively involved in the Interagency Council on Homelessness which seeks to coordinate services among agencies for this especially vulnerable population.

In terms of alignment of state programs, the most significant development has been the move of Alcohol and Drug Abuse Prevention (ADAP) from the state Health Department to the Department of Human Services and its merger with the former Division of Mental Health Services to form the current Division of Behavioral Health Services. The first fruits of this organizational realignment are described under Recommendation 4.3, below.

The Division of Behavioral Health Services also seeks to better align service provision with needs through cooperative efforts with other divisions of DHS and other state agencies. In addition to the work with the DHS Division of Medical Services (Medicaid) described above, DBHS has worked with the Developmental Disabilities Services division to develop coordinated programs, in particular, a new unit at the Arkansas State Hospital that will serve adolescents with both mental illness and a developmental disability. If a recently applied for grant is received DBHS will be working with the Division of Aging to systematically assess the state's long-term care system.

In terms of work with other state agencies to align services, DBHS maintains an agreement with the Vocational Rehabilitation Services to allow use of DBHS funds to provide mental health services for its clients receiving supported employment and other employment services. During the past year, DBHS participated in a taskforce involving representatives of various aspects of criminal justice to address the mental health needs of persons incarcerated in local jails. Although the proposals from this taskforce were not funded in the last legislative session, the work of this group did help DBHS secure increased funding to expand local acute inpatient psychiatric beds which, in part, will meet the needs of jailed persons for acute inpatient psychiatric care. Also, as a result of the work of this taskforce, DBHS has modified its service tracking system to specifically identify the volume of need for inpatient care of jailed individuals and the extent to which this need is currently being met.

Recommendation 2.4: Create a comprehensive State Mental Health Plan.

The most comprehensive State Mental Health Plan for adults is the State Plan developed as part of the Mental Health Block Grant Application. With a more systematic approach to input from AMHPAC and following evolving plan development guidelines from SAMHSA, this plan has become progressively more comprehensive and meets some of the goals set forth in the NFC report, in terms of increased accountability and expanding service options. However, the plan is not all that is envisioned in the NFC report. Although including some coordination with agencies outside the traditional State mental health agency (see Recommendation 2.3, above), it is still largely focused on the State mental health agency.

Recommendation 2.5: Protect and enhance the rights of people with mental illness.

This NFC recommendation focuses on both the right of consumers to be fully integrated into their communities and the right to be free of unnecessary seclusion and restraint during any time the consumer may be in an institutional setting.

Arkansas' Olmstead Plan and its follow-up implementation effort (Governor's Integrated Services Taskforce- GIST) have, to-date, had only minimal focus on the mentally ill. This in part reflected the reality that Arkansas' only state hospital is (except for court order forensic patients) a short-term acute care facility; but, this ignores the other ways in which the mentally ill are not fully integrated into the community. However, recently, the chair of AMHPAC has been elected vice-chair of GIST and this may provide some greater opportunity for increased focus on the issue of greater community inclusion of those with a mental illness.

The Division of Behavioral Health Services has an active program to reduce the use of seclusion and restraint in the two institutions it operates- the Arkansas State Hospital (ASH) and the Arkansas Health Center (AHC-a skilled nursing facility). The program began in 2003, when senior DBHS, ASH and AHC staff attended NTAC training in this area. This was followed up with initial and going training of all institutional staff. ASH administration also instituted daily senior management meetings in which all incidents of seclusion and restraint are reviewed. Incidents of seclusion and restraint are regularly monitored and reported and have shown a significant decline over the past four years.

Recommendation 3.1: Improve access to quality care that is culturally competent.

The Arkansas State Hospital (ASH) provides four-hours of training in cultural competence to all new employees and a 2 hour update to all employees yearly. Last year ASH also conducted several unit meetings focused on integrating cultural competency principles into treatment planning and service delivery.

For the past four years DBHS has been an active participant with NAMI-Arkansas and the U.A.M.S. in the Partners in Outreach Coalition. The Coalition carries out ongoing training for ministers, including minority ministers, in recognizing when individuals who come to them for counseling could benefit from mental health treatment and in how to deal with the stigma that

might prevent some from seeking this treatment. This group meets every other month and also sponsored a related conference attended by over 300 ministers last year.

DBHS' Assistant Director for Minority Affairs has provided training to the staffs of several of the states CMHCs on the provision of culturally component care, and has consulted with the management of one of these centers on development of policy in this area.

With the initiation of the statewide MHSIP consumer survey in 2005, DBHS has begun tracking system performance in this area. In the 2006 adult survey 79% of respondents "Agreed" or "Strongly Agreed" with the statement, "Staff was sensitive to my cultural background." DBHS plans to further analyze this data in terms of any differences in response rate among minority groups.

Recommendation 4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

As reported in previous block grant applications, the former Division of Mental Health Services (DMHS) and former office of Alcohol and Drug Abuse Prevention (ADAP) were merged into the Division of Behavioral Health Services (DBHS) effective July 1, 2003. Division level administrative staffs were co-located on October 1, 2003. Also, as noted in previous applications, the staffs from both Mental Health and ADAP worked together to submit a COSIG grant proposal for infrastructure development to provide integrated mental health and substance abuse services. DBHS was informed in the fall of 2003 that it had received this grant in the amount of $1.1 million a year for three years, with lesser amounts in years four and five. Implementation of this grant has been the primary vehicle though which initial steps are being taken to integrate the service delivery systems of these aspects of behavioral health care. The primary focus of the grant has been to implement system-wide screening for co-occurring disorders, with the goal being that all mental health (MH) providers will use a common instrument to screen for substance use disorders and all substance abuse (SA) treatment providers will use a common instrument to screen for mental health disorders. The grant has supported planning and training activities attended by both mental health and substance abuse providers. Twelve of the state's fifteen CMHCs participated in the COSIG grant activities focused on implementing a common assessment instrument. DBHS has now made use of the COSIG screening instrument (or a DBHS approved alternative) a contract requirement for all CMHCS effective July 1, 2007.

As just described, there has been substantial progress made in achieving system-wide screening for co-occurring disorders. The next step, of linking this with integrated treatment, has much work yet to be done. There have been some reports of enhanced communication, referral, cooperation and initial steps toward providing integrated treatment between SA and MH providers resulting from the joint participation in COSIG training activities. Also, to further the goal of integrated treatment, DBHS has begun to link the MH and SA data system (each using SSN as common unique identifiers) so as to be able to track client movement between the systems.

Recommendation 4.4: Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

There is no current comprehensive plan to promote the screening for mental disorders in primary health care and connect to related treatment and supports. As previously noted, one of the state's CMHCs co-locates programs with primary health care providers and in these settings there is routine screening for mental health problems associated with physical health problems and referral for needed mental health treatment in-house. For the past two years, DBHS has contracted with the State Health Department to include optional modules in its annual BRFSS surveys to collect population data on the incidence of anxiety, depression and serious mental illness. Data from these surveys could be used to highlight the scope of the problem and possibly serve as a basis for supporting efforts in this area.

Recommendation 5.1: Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

Although DBHS is primarily a service agency it has, in limited ways, participated in research to promote recovery and resilience. In past years DBHS cooperated with the adjacent University of Arkansas for Medical Sciences in research projects on validating treatment Outcome Modules and to study the effectiveness of behavioral interventions in nursing home settings. As noted above, DBHS is currently an active participant in an ongoing study of the effectiveness of interventions for those with schizophrenia focused on assisting them to manage their diabetes. Senior DBHS staff serves on the planning and implementation committee for this study. These staff assisted in developing the studies' evaluation and intervention protocols and assisted in recruiting CMHCs as partners in the project.

Recommendation 5.2: Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

As part of its system transformation activity, the previous two year's plans have noted the DBHS priority of beginning to move the system to greater availability of evidenced-based practices (EBP). Assertive Community Treatment (ACT) is the EBP that DBHS has had the longest standing and most direct financial role in supporting. DBHS funded the start-up and initial several years of operation of the state's first ACT program (GAIN). This program has served as a demonstration project for ACT and has assisted in training staff of a couple other CMHCs to start up ACT programs.

The community providers in the public mental health system, Community Mental Health Centers and Clinics (CMHC), are all independent, private, non-profit organizations. Some of these CMHCs have undertaken the development of EBPs on their own initiative, without DBHS mandate or additional financial support, although with DBHS encouragement and technical support. In this manner, three additional ACT programs had been developed; although DBHS was recently informed that due to lose of staff one of these programs has now been discontinued.
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DBHS' initial efforts to promote wider dispersal of EBPs within the community-based system of care also includes obtaining and making public information on the current status of the provision of these services including the specific EBPs provided by each CMHC and the number of clients

receiving these services. DBHS collected data reporting on the provision of EBPs during state fiscal year (SFY) 2006, and in a new annual Special Services Program report distributed this information to all CMHC executive directors, Presidents of CMHC Boards of Directors and other stakeholders, including the Arkansas Mental Health Planning and Advisory Council (AMHPAC) and the state NAMI organization. As others have noted, "what you count is what you get;" and, it has been DBHS' experience that, in some instances, merely counting and reporting a phenomenon can result in its increase. The data in the SSP report will also serve as the basis for planning for other systematic efforts to increase the availability of EBPs.

DBHS will also continue its informal encouragement and technical support to CMHCs wishing to implement EPBs on their own initiative. One area of particular technical support is consultation with CMHCs regarding billing components of various EBPs under Medicaid. To date DBHS has not formed any public-private partnership to guide the implementation of EBPs.

Recommendation 5.3: Improve and expand the workforce providing evidence-based mental health services and supports.

All efforts noted in Recommendation 5.2 to expand the availability of EBPs, of course, involve improving and expanding the related workforce. Also, as noted there, EBPs are provided by independent CMHCs and DBHS has generally not had a direct involvement in training staff at those Centers. The primary exception to this has been DBHS' role in funding, organizing and providing the COSIG training related to screening for co-occurring disorders.

Through the state Medicaid agency, DBHS' Medical Director is involved in a program to train physicians in best practices in prescribing second generation antidepressants and medications for ADHD.

Although not specific to EBPs, DBHS plays a significant role in training a more competent and expanded mental health workforce through its Research and Training Institute (RTI). Through RTI and its affiliation with the adjacent University of Arkansas for Medical Sciences, DBHS participates in training psychology interns and psychiatry residents. The Institute also provides fellowships in forensic and geriatric psychiatry.

Recommendation 5.4: Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

DBHS is making some contribution to the knowledge base in two of the four understudied areas noted.

In the area of acute care, DBHS has operated for the past three years an innovative local acute care program which for next year (SFY 2008) is funded at the level of $11.5 million. In this program, the state's CMHCs provide utilization management of services and provide alternatives to hospitalization, in part funded from savings achieved through diverting from inpatient care. DBHS has collected extensive data on the operation of this program, including rates of diversion and variances in type of diversions from inpatient care, average lengths of inpatient stay, and average and variances in market set reimbursement rates. DBHS is adding additional tracking to

the data collection system for SFY 2008 to capture data on the level of unmet need for acute inpatient care, including in particular, among those incarcerated in jail.

With a statewide MHSIP consumer satisfaction survey initiated in 2006, and expanded in sample size for 2007 to provide individual provider organization level results, DBHS is gathering information on differences among racial and ethnic groups in levels of satisfaction with public mental health services.

Recommendation 6.2: Develop and implement integrated electronic health record and personal health information systems.

DBHS has had limited involvement in the development and implementation of integrated electronic health records and personal health information systems. The Arkansas State Hospital has undertaken the evaluation of available electronic medical records with the goal of eventual implementation, but there are not specific implementation plans at this time.

Various CMHCs have undertaken to implement electronic medical records but DBHS has had no direct involvement in these implementation efforts.

DBHS did participate on a committee of the Mental Health Council of Arkansas (the trade association of the state's CMHCs) to develop a standardized medical record to be used by all CMHCs. A significant focus of DBHS's participation was to insure that the record contained all data elements needed to be able to use this record to provide data for URS reporting. The standardized medical record has been adopted in full by some CMHCs, but only in part by others. A uniformly adopted standardized record would be supportive of the eventual development of an integrated statewide medical record and data system.

Arkansas

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 2: Mental health system data epidemiology
A. Estimate of Prevalence

Arkansas' total population is 2.7+ million of which 75% are adults, age eighteen and older. The 2000 census data shows that 80% of the population is white; 15.7% is black or African American; less than 1% is American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander, and; 3.2% is Hispanic or Latino. Over the last eleven years, Arkansas' Hispanic population has significantly increased. In 1990, the state total was 19,876 and in 2000, the total was 86,866—an increase of 66,990. U. S. Census figures indicate Arkansas' population is divided between 49% urban and 51% rural residents. There are 75 counties in the state—12 of which would be considered urban and 63 considered rural. The per capita income was reported to be $19,595 in the 2000 census. Arkansas uses the latest (2006, released June 14, 2007) federal prevalence estimate of serious mental illness of 114,199.

As described above, the state of Arkansas uses the federal definition to identify persons with a serious mental illness. In SFY 2006, the public mental health system provided services to 66,545 mental health clients of whom 45,232 were adults. Approximately 58% (26,235) of these adult persons served are identified as having a serious mental illness. DBHS will continue to monitor the penetration of the public mental health system in terms of providing services to its target population of adults with a serious mental illness.

At the request of SAMHSA, DBHS initiated contact with the state's Department of Health and contracted for it to include in its 2006 Behavioral Risk Factor Surveillance System (BRFSS) the optional module PHQ 8 (a measure of the prevalence of anxiety and depression), and the optional module 16 (measuring the incidence of serious mental illness and stigma related to mental illness) in the 2007 BRFFS. DBHS anticipates being able to use information from these surveys to begin assessing the extent of unmet need.

Arkansas

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 2: Mental health system data epidemiology
B. Quantitative Targets

In previous block grant Applications Arkansas has established its quantitative target for services to the seriously mentally ill in terms of the percentage of the estimated seriously mentally ill served in the public mental health system. The target for SFY 07 was set at a 20% penetration rate. Per this year's block grant procedures Arkansas is setting its quantitative target in absolute number terms rather than as a percentage. The target set for SFY 08 is 24,000.

Arkansas

Adult - Transformation Efforts and Activities in the State in Criteria 2

Adult - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 2: Mental health system data epidemiology
C. Transformation Efforts and Activities

Although the Division of Behavioral Health Services (DBHS) has undertaken some initiatives in the adult system of care that further some of the transformation goals outlined in the New Freedom Commission (NFC) report, including those focused on developing a recovery oriented system, this 2008 Block Grant Application represents DBHS' first systematic review and documentation of these mental health system transformation efforts. This review is organized around the 19 recommendations subsumed under the six NFC goals. Most of these 19 recommendations focus primarily on the development of a comprehensive community-based mental health service system and the efforts and activities on these recommendations are reviewed under Criterion 1 above. Recommendations 3.2 and 6.1 (related to improved access in rural areas) are addressed below under criterion 4 below. Transformation efforts and activities related to recommendation 1.1 are reviewed here, under Criterion 2. (Note that recommendations 4.1 and 4.2 are related to children's services and are addressed in the children's portion of this application.).

Recommendation 1.1: Advance and implement a national campaign to reduced the stigma of seeking care and a national strategy for suicide prevention.

In 2000 DBHS undertook a statewide anti-stigma campaign. A local advertising agency was engaged to help develop this campaign. A number of television and radio commercials were produced and for a two year period were run systematically around the state. The theme of this campaign was that mental illness, like many physical illness, is very treatable, and persons were urged to seek treatment. There was specific inclusion of minorities as subjects of the commercials. The campaign also involved print material, including a brochure presenting the anti-stigma message and providing a toll free number through which individuals could access mental health information and referral resources. This information line, which continues to operate, is run by NAMI-Arkansas under a contact with DBHS. The information phone line averaged over 50 calls per month during the two years advertisements were being run, and currently averages between 15 to 20 calls per month.

In addition to the statewide effort described above, local CMHCs pursue anti-stigma efforts on their own initiative. For example, one of DBHS' certified mental health clinics that serve adults with severe and persistent mental illness, sponsors a widely-advertised annual art show and sale of clients' work. This organization also has a client choir that performs at community functions. Both of these activities show individuals with severe and persistent mental illness in a positive light, engaged in creative and self-fulfilling activities.

DBHS does not sponsor a specific suicide prevention program. However, the public mental health system does provide 24 hour per day crisis response throughout the state. A significant portion of the emergencies responded to deal with potential suicides. In SFY 2006, CMHCs

reported providing approximately 14,000 Single-Point-Of-Entry screenings of individuals being considered for acute hospital admission, and this 14,000 number counts only the emergency responses specifically related to hospitalization.

Arkansas

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 4: Targeted services to rural and homeless populations
A. Outreach to Homeless

The current estimate of homeless SMI adults with a serious mental illness in Arkansas is 2,981. The 2000 census reports a total state population of 2,673,400. Of this number, 17.5 %, or 467,845, are reported to live below the federal poverty level. Children are reported to represent 25.4% of the total population (679,044), and 25% of these children (169,761) are reported to live below the federal poverty level. The number of adults living below the poverty level is calculated to be 298,084 (467,845 – 169,761). It is estimated that 2% of the adults living in poverty, or 5,962, are homeless. It is estimated that 50% of these homeless adults, or 2,981, have a Serious Mental Illness.

All CMHCs provide services to the homeless. A person's housing status is routinely assessed at the time of admission. However, several, especially those without a PATH grant, report difficulty in making outreach to and tracking services to this population. The major initiative for providing mental health services to homeless persons is through the CMHCs receiving a PATH Grant. The DBHS issues a request for proposals to providers of public mental health services to fund services specifically for persons who are suffering from serious mental illness or serious mental illness and substance abuse and are homeless or at-risk of becoming homeless. Arkansas plans to continue its method of distributing PATH funds through a competitive RFP process that includes demonstration of need. This method helps focus the additional support of PATH funding in the areas of most need. The PATH Grant ($300,000) funded five programs in SFY 2006. These programs use assertive outreach to homeless individuals by seeking them out in the places where they tend to gather. Once identified, needed services can be provided at a location where the person feels comfortable and safe. PATH Grant recipients collaborate with other service agencies to coordinate services and facilitate outreach. For the most recent grant year reporting cycle (9/1/05 – 8/31/06), 1,008 adults with a serious mental illness were provided services through a PATH grant.

At the DBHS level, a staff person is a member of the Interagency Council on Homelessness, participates in the Community Homeless Assessment Local Education Networking Group (CHALENG), a Veteran's Administration committee coordinating services among homeless providers, and participates in the consolidated plan and continuum of care planning activities.

Housing status, including homelessness, is one of the fields in DBHS' new enhanced data system that became operational For SFY 2006. Thus, for the first time, DBHS was able to determine unduplicated counts of homeless clients served. The amount of duplication in the previous counts reported was unknown. For SFY 2007, DBHS set its target at serving 35% of the estimated homeless with serious mental illness. This target was set prior to data for SFY 2006 being available and, as was anticipated in the 2007 Applicatoin, it was necessary to modify this

target downward to 23% based on the 2006 results from unduplicated data. For SFY 2008 DBHS continues its target at 23%.

Arkansas

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 4: Targeted services to rural and homeless populations
B. Rural Area Services

Arkansas' public community mental health system was largely developed to serve a rural population and continues to have a significant focus on serving this population. Although becoming somewhat more urbanized, Arkansas continues to have a significant rural population. Based on the United States census definition of Standard Metropolitan Statistical Areas, Arkansas has 12 counties that are considered urban and 63 that are considered rural. According to the 2000 census, the 63 counties considered rural are home to 51% of the adult (18 years of age and older) population.

DBHS plans to continue its emphasis on services in rural areas including the wide dispersal of service sites, the provision of off-site services and the provision of extensive transportation services. The goal is that as a percentage of the population of the county in which they reside, the number of adults with a serious mental illness served in rural counties will at least equal that for urban counties. In effect this means that the service penetration rate in rural counties will at least equal that in urban counties. As previously noted, CMHCs have service sites in 69 of the states 75 counties and deliver services in all 75 counties. To further increase access by those in rural areas, many CMHCs run fleets of vans to pick up those clients needing services and many case managers transport clients in their private automobiles. For SFY 2007, CMHCs projected that they would operate 262 vehicles (with a total seating capacity of 3,013) to provide client transportation. CMHCs projected that these vehicles would travel a total of 3,483,558 miles during the year.

To promote the use of telemedicine to bring services to rural areas, DBHS worked with the state Medicaid agency to include within the state's rehab option plan a menu of services for which Medicaid would reimburse when these services were delivered via telemedicine. DBHS also worked with Medicaid on the development of the procedures providers were to follow in delivering these services. Beyond this activity, DBHS has not been involved in any systematic efforts to expand the use of telemedicine in rural areas. DBHS is aware that some local CMHC providers have undertaken development in this area, but does not have a systematic accounting of the extent of this development.

Arkansas

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

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Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 4: Targeted services to rural and homeless populations
C. Older Adults

Services for Older Adults are provided throughout Arkansas' public mental health system, in both its institutional programs directly operated by DBHS, and in the community programs operated by the state's local CMHCs. However, it does appear that this group is underserved. During SYF 2006, 3.5 % (2,338) of the clients served in the public mental health system were age 65 and older, while this age group represented 13.9% of the state's populations.

There are currently no specific, system-wide, coordinated outreach or intervention programs directed to the elderly population. Some of the state's local CMHCs have programs focused specifically on serving the elderly, and DBHS has some limited activity in this area. Through the PASRR process, elderly individuals being considered for nursing home placement are evaluated for need for mental health treatment. In some instances it is possible to achieve a diversion from nursing home placement by providing community-based mental health services. In instances where the individual is placed in a nursing home, the PASRR process makes referrals for needed mental health care to be provided in the nursing home setting.

The state's Division of Adult and Aging Services has received a Money Follows the Person grant focused on moving individuals, including the elderly, out of nursing home care, into the community. DBHS has a staff liaison to this program and through this program efforts will be made to move elderly residents out of the skilled nursing facility operated by DBHS- the Arkansas Health Center.

Starting this fiscal year, in collaboration with the University of Arkansas for Medical Sciences, DBHS is supporting a geriatric psychiatric fellowship, with the fellow spending one day per week at the Arkansas Health Center skilled nursing facility and being supervised by the Division' Medical Director.

Arkansas

Adult - Transformation Efforts and Activities in the State in Criteria 4

Adult - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities- Adult
Criterion 4: Targeted services to rural and homeless populations
D. Transformation Efforts and Activities

Although the Division of Behavioral Health Services (DBHS) has undertaken some initiatives in the adult system of care that further some of the transformation goals outlined in the New Freedom Commission (NFC) report, including those focused on developing a recovery oriented system, this 2008 Block Grant Application represents DBHS' first systematic review and documentation of these mental health system transformation efforts. This review is organized around the 19 recommendations subsumed under the six NFC goals. Most of these 19 recommendations focus primarily on the development of a comprehensive community-based mental health service system and the efforts and activities on these recommendations are reviewed under Criterion 1 above. Transformation efforts and activities related to recommendation 1.1 (reducing stigma) are reviewed under Criterion 2 above. Recommendations 3.2 and 6.1 are addressed here under criterion 4. (Note that recommendations 4.1 and 4.2 are related to children's services and are addressed in the children's portion of this application.).

Recommendation 3.2: Improve access to quality care in rural and geographically remote areas.

As noted in previous Block Grant applications, Arkansas' public community mental health system was largely developed to serve a rural population and continues to have a significant focus on serving this population. Although becoming somewhat more urbanized, Arkansas continues to have a significant rural population. Based on the United States census definition of Standard Metropolitan Statistical Areas, Arkansas has 12 counties that are considered urban and 63 that are considered rural. According to the 2000 census, the 63 counties considered rural are home to 51% of the adult (18 years of age and older) population. DBHS plans to continue its emphasis on services in rural areas including the wide dispersal of service sites, the provision of off-site services and the provision of extensive transportation services. As reported in previous Implementation Reports, the service penetration rate in rural counties is comparable to that in urban counties.

As noted below in Recommendation 6.1, some initial steps have been taken to use telemedicine to bring quality care to rural and geographically isolated areas.

Recommendation 6.1: Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

DBHS worked with the state Medicaid agency to include within the state's rehab option plan a menu of services for which Medicaid would reimburse when these services were delivered via telemedicine. DBHS also worked with Medicaid on the development of the procedures providers were to follow in delivering these services. Beyond this activity, DBHS has not been involved in any systematic efforts to expand the use of telemedicine in rural areas. DBHS is

aware that some local CMHC providers have undertaken development in this area, but does not have a systematic accounting of the extent of this development.

Arkansas

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Adult
Criterion 5: Management Systems
A. Resources for Providers

Financial Resources

DBHS-controlled funds budgeted for SFY 2008 are shown in TABLE 1 below.

TABLE l. SFY 2008 DBHS-CONTROLLED FINANCIAL RESOURCES

COMMUNITY PROGRAM FUNDING	
CMHCs grants for basic services to priority populations	7,409,209
CMHCs per capita grants for basic program operations	8,780,603
CMHCs grants for alternative to ASH utilization	2,653,236
CMHCs grants for local acute care-continuing	5,800,000
CMHC grants for local acute care-new	5,750,000
CMHCs grants for CASSP activities	1,240,000
CMHC federal block grant allocation	3,708,056
CMHC PATH grants	300,000
Outpatient Forensic Evaluations-fee for service	460,000
GAIN for Assertive Community Treatment (ACT)	981,120
Community Program Subtotal	**37,082,224**
NON-COMMUNITY PROGRAM FUNDING	
Arkansas Research and Training Institute	589,955
Arkansas State Hospital	27,543,136
Arkansas Health Center Skilled Nursing Facility	5,414,196
Non-Community Subtotal	**33,547,287**
GRAND TOTAL	**70,629,511**
Community Program Funding as Percent of Total Funding	**52.5%**

The total budget for mental health controlled by DBHS is approximately $70 million per year. DBHS-controlled funds budgeted for community-based programs for SFY 08 total $37,082,224 or approximately 52.5% of the DBHS budget. Budgeted funds are subject to being reduced if the state experiences a revenue shortfall as has occurred in some previous years. However, the state currently has a significant surplus and no shortfall is anticipated in SFY 2008. Note that, starting two years ago, DBHS made significant changes in the methodology for computing DBHS-Controlled Financial Resources. Medicaid funds, which are not controlled by DBHS, have been excluded in the calculation of both Community and Non-Community program budgets. In past years, the totals for Community Programs did not include Medicaid funding, which is not under

the control of DBHS. However, Medicaid funds were included in the calculation of Non-Community Program Funding, even though these Medicaid funds are also not controlled by DBHS. The new methodology more accurately reflects DBHS' actual control of funds and its allocation priorities. Note that because of increased institutional operating costs the percent of DBHS-controlled funds allocated to community programs is projected to decrease for SFY 2008, however, DBHS continues its goal of having at least fifty percent of the funds under its control devoted to community-based programming.

The public mental health system in Arkansas relies heavily on Medicaid funding. In SFY 2006, the Community Mental Health Centers and Clinics received approximately $118 million in reimbursements under the Medicaid rehab option. This represents an 8% increase over Medicaid funds received for SFY 2005. The total budgets for Community Mental Health Centers and Clinics for SFY 2006 (for providing both adult and children's services) was approximately $205 million, a 10% increase over SFY 2005.

Staffing Resources

For SFY 2007, the community-based public mental health system employs approximately 3,141 staff. All staff providing direct services through the community system are either licensed or certified by the State. All CMHCs have psychiatrists, with support from psychologists, social workers, licensed professional counselors, registered nurses, licensed psychiatric nurses, case managers, and various administrative staff. The CMHC system offers approximately 65 internships in various disciplines including psychology, social work, and nursing. Recruiting and retaining mental health professionals is always challenging and the challenge has recently taken on increasing proportions. Psychiatrists are always in short supply and locating those willing to work in rural areas is difficult. For SFY 2007, there were a total of 57.5 FTE psychiatrists, 63.7 FTE doctoral psychologists, and 819.2 FTE mental health professionals of all type (doctoral and masters level) employed by the CMHCs.

Training of Service Providers

The DBHS makes significant efforts to provide training opportunities for the mental health system. The state hospital is certified as an intern training site for three psychologists pursuing a doctoral degree, and also serves as an intern site for second year social workers. DBHS provides financial, training-site and supervision support of the adjacent University of Arkansas for Medical Science's psychiatry residency and child, forensic and geriatric psychiatry fellowships. The DBHS sponsors yearly training related to conducting both children and adult forensic evaluations.

Through the Arkansas Research and Training Institute (RTI), DBHS collaborates with community providers and various training schools to promote the use of state-of-the-art practices. The Institute has consultation teams available to assist providers with innovative treatment approaches particularly in the area of services for persons with a mental illness and a substance abuse disorder.

In addition to the DBHS-sponsored activities, the CMHCs provide regular in-service training to staff and other providers to keep them informed of current mental health practices and policies. Participants include clinical providers, law enforcement personnel, local hospital staff, emergency room staff, and others who may come into frequent contact with persons with mental illness. The Council of CMHCs, with support from DBHS, sponsors an annual four-day Behavioral Health Institute that provides extensive training opportunities to over 1,000 attendees, including staff of CMHCs, clients, family members and advocates.

Arkansas

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Adult
Criterion 5: Management Systems
B. Emergency Service Provider Training

Staff from the Division of Behavioral Health Services (DBHS) provide training at the Law Enforcement Training Academy for persons seeking to become certified law enforcement officers. As part of a SAMHSA grant, DBHS and a partner CMHC provide training to Little Rock, Arkansas police officers on crisis management. Through the local acute care programs, CMHCs have regular, frequent and on-going contact with staff of hospital emergency rooms that includes educating these staff regarding appropriate referrals to the public mental health system and the procedures for making these referrals.

Arkansas

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Adult
Criterion 5: Management Systems
C. Grant Expenditure Manner

Block Grant funds are allocated on a per capita basis to fifteen CMHCs to support services to targeted clients as mandated by the law. In addition to funding services through the community mental health centers, the Block Grant is used to support some administrative and training activities, and for the first time this year, supports a program (GAIN) providing the evidenced based practice of Assertive Community Treatment. The details of the allocation of these Block Grant funds are shown in TABLE 2.

TABLE 2. SFY 2008 FEDERAL BLOCK GRANT ALLOCATIONS

COMMUNITY MENTAL HEALTH CENTERS	SMI Adult	SED Child	Total
Community Counseling Services	$135,766.44	$73,743.09	$209,509.53
Counseling Associates	$172,438.91	$110,925.09	$283,364.00
Counseling Clinic	$67,049.59	$43,031.13	$110,080.72
Counseling Services of Eastern Arkansas	$112,967.45	$89,221.43	$202,188.88
Delta Counseling Associates	$67,202.53	$45,698.83	$112,901.36
Little Rock Community Mental Health Center	$145,543.90	$92,237.01	$237,780.91
Mid-South Health System	$200,906.42	$129,675.87	$330,582.29
Health Resources of Arkansas	$184,009.66	$104,074.82	$288,084.48
Ozark Counseling services	$88,698.29	$46,497.73	$135,196.02
Ozark Guidance Center	$280,583.34	$182,451.50	$463,034.84
Professional Counseling Associates	$193,898.06	$127,574.47	$321,472.53
South Arkansas Regional Health Center	$100,049.32	$64,799.51	$164,848.83
Southeast Arkansas Behavioral Healthcare Systems	$115,802.25	$74,906.04	$190,708.29
Southwest Arkansas Counseling and Guidance Center	$91,768.96	$62,839.69	$154,608.65
Western Arkansas Counseling and Guidance Center	$189,908.66	$128,383.48	$318,292.14
CMHC Subtotal	$2,146,593.78	$1,376,059.69	$3,522,653.47
ADMINISTRATION			$402.78
GRANT TO AR. COUNCIL OF CMHC's			$10,000.00
GRANT TO NAMI-ARKANSAS			$85,000.00
GRANT TO GAIN			$90,000.00
TOTAL			$3,708,056.25

Explanation of Transformation Expenditures

Table 3 on the following page gives an explanation of the transformation expenditures reported in Table 4 in the following section.

TABLE 3. Transformation Expenditures Explanation

SGR = State General Revenue, BG = Federal Mental Health Block Grant

SOURCE	AMOUNT	EXPLANATION
Improving coordination of care among multiple systems		
SGR	$1,050,000	Children's System of Care implementation funding
SGR	$123,682	Personnel costs for CASSP Administration (1.0 CASSP Coordinator, 0.5 Assistant Director for Children's Services).
Support for culturally competent services		
SGR	$39,811	0.5 Personnel costs, Assistant Director for Minority Affairs
Involving consumers and families fully in orienting the MH system toward recovery		
BG	$25,000	Estimated portion of NAMI grant devoted to of consumer and family involvement in orienting system to recovery
SGR	$32,786	Personnel costs, Consumer Advocate
Support for consumer- and family-operated programs, including Statewide consumer networks		
BG	$25,000	Estimated portion of NAMI grant devoted to consumer/family operated program.
Services for co-occurring mental and substance use disorders		
Other Grant	$100,000	COSIG grant to develop infrastructure to support integrated treatment. An additional $1,356,743 carryover request is pending.
Eliminating disparities in access to and quality of care		
Support for integrated electronic health record and personal health information systems		
SGR	$10,000	Estimated personnel costs for evaluating options for ASH electronic medical record.
Improving consumer access to employment and affordable housing		
Other Grant	$300,000	PATH program at five CMHCs
Provision of Evidence Based Practices		
BG	$90,000	To GAIN to support ACT program
SGR	$891,120	To GAIN to support ACT program
Aligning financing for mental health services for maximum benefit		
Supporting individualized plans of care for consumers		
BG	$178,599	Estimated CMHCs portion of block grant allocated to individualized treatment planning: Total to CMHCs ($3,522,653) **x** Percent of Service Activity Devoted to Individualized Treatment Planning (0.0507).
Supporting use of peer specialist		
SGR	$33,000	Two peer providing support groups at ASH & related workshop
Linking mental health care with primary care		
Supporting school mental health programs		
SGR	$20,000	Grants to three CMHCs to support school based and PBIS services (collaborative with Dept. Education which provides additional funds)
Supporting early mental health screening, assessment, and referral to services		
Suicide prevention		
Supporting reduction of the stigma associated with mental illness		
BG	$7,000	To NAMI to support AETN call in show
BG	$28,000	Estimated portion of NAMI grant devoted to community education activities
SGR	$10,360	SGR grant dollars allocated to Information Line
Use of health technology and telehealth to improve access and coordination of mental health care		
Supporting workforce development activities		
BG	$10,000	To Mental Health Council of Arkansas to support annual Behavioral Health Institute.
Other (specify)		

Table 4
FY 2008 – FY 2010 MHBG Transformation Expenditures Reporting Form
State: Arkansas

Number	State Transformation Activity	FY 2008 MHBG Planned Expenditure Amount	FY 2008 Other State Funding Source Amount
1	Improving coordination of care among multiple systems		1,173,682
2	Support for culturally competent services		39,811
3	Involving consumers and families fully in orienting the MH system toward recovery	25,000	32,786
4	Support for consumer- and family-operated programs, including Statewide consumer networks	25,000	
5	Services for co-occurring mental and substance use disorders		100,000
6	Eliminating disparities in access to and quality of care		
7	Support for integrated electronic health record and personal health information systems		10,000
8	Improving consumer access to employment and affordable housing		300,000
9	Provision of Evidence Based Practices	90,000	891,120
10	Aligning financing for mental health services for maximum benefit		
11	Supporting individualized plans of care for consumers	178,599	
12	Supporting use of peer specialist		33,000
13	Linking mental health care with primary care		
14	Supporting school mental health programs		20,000
15	Supporting early mental health screening, assessment, and referral to services		
16	Suicide prevention		
17	Supporting reduction of the stigma associated with mental illness	35,000	10,360
18	Use of health technology and telehealth to improve access and coordination of mental health care		
19	Supporting workforce development activities	10,000	
20	Other (specify)		

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	24,000	24,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or expand access to mental health services for the population of adults with serious mental illness.

Target: The public mental health system will serve at least 24,000 persons with a serious mental illness.

Population: Adults with a serious mental illness receiving services in the public mental health system.

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Number of adults with a serious mental illness that receive treatment in the public mental health system.

Measure: Number of adults with a serious mental illness that receive treatment in the public mental health system.

Sources of Information: DBHS' Enhanced Data Reporting System, Service Process Quality Management (SPQM).

Special Issues: Prior to SFY 2006, the number served data was based on reporting that did not have system-wide unique client identifiers, so it was not possible to calculate unduplicated counts of those served. Effective for SFY 2006 the data system contrained system-wide unique client identifiers that allowed the determination of the unduplicated number of clients served. The amount of duplication in the previous counts was unknown, and for this reason, the goal for SFY 2006 was to establish a performance baseline. For SFY 2006, 26,657 adults with a serious mental illness were reported to have been served. Possible fluctuation in the unduplicated number served is unknown and DBHS conservatively projects at least 24,000 persons with serious mental illness will be served in SFY 2007 and maintains this number as a target for SFY 2008.

Significance: Setting quantitative goals for the number of adults with a serious mental illness to be served in the public mental health system is a key requirement for the mental health block grant legislation. Quantitative goals in this area also serve as a benchmark for access to the system.

Action Plan: DBHS' contracts with community providers specify those with SMI as a priority service population. DBHS tracks and publishes the number served by each contracted provider. Prior to SFY 2006, the total SMI population served was reported only semi-annually. With its new data system enhancements, DBHS had initially planned to publish the number being served by each provider on a monthly basis, starting in SFY 2007. Although delays in data system development did not make this feasable for SFY 2007, DBHS now plans to initiate the monthly publication at some point in SFY 2008.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	7.20	7.60	10	10	N/A	N/A
Numerator	68	68	--	--	--	--
Denominator	943	891	--	--	--	--

Table Descriptors:

Goal: Short-term readmission to the Arkansas State Hospital (ASH) will be reduced to the extent possible.

Target: Fewer than 10% of adult patients discharged from the Arkansas State Hospital will be readmitted within 30 days of discharge.

Population: Adults discharged from the Arkansas State Hospital.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adults readmitted within 30 days of discharge from the Arkansas State Hospital.

Measure: Numerator: Number of discharges of adults followed by readmission within 30 days of discharge. Denominator: Number of discharges of adults from the Arkansas State Hospital.

Sources of Information: Arkansas State Hospital Data System.

Special Issues: In order to be able to report 180-day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year (calendar 2007) rather than the most recent state fiscal year (2008) which serves as the time period for other indicator targets in this plan. Discharges include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded at some point in the future.

Significance: A hallmark of an adequate aftercare with comprehensive community-based services is the ability to avert rehospitalization within a brief period following discharge.

Action Plan: Maintaining a low rate of 30-day readmissions is accomplished by assuring prompt and appropriate aftercare. DBHS' contracts with CMHCs require that they make aftercare appointments for persons being discharged from ASH available within two weeks of the date of discharge. The ASH social work department contacts each CMHC prior to a patient's discharge and arranges for this timely aftercare appointment. At the time of this contact, the ASH social work staff also brings to the attention of the CMHC the individualized follow-up needs of the patient including current medications and housing needs. ASH social work staff also assess the need for and make appropriate follow-up arrangements to respond to special client needs including, in particular, making referral for follow-up by an assertive community treatment (ACT) program or the other services of one of the three DBHS-certified specialty Mental Health Clinic providers that focus on providing services to those with the highest level of service needs.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	15.90	17.70	25	25	N/A	N/A
Numerator	150	158	--	--	--	--
Denominator	943	891	--	--	--	--

Table Descriptors:

Goal: Intermediate term readmission to the Arkansas State Hospital will be reduced to the extent possible.

Target: Fewer than 25% of adult patients discharged from the Arkansas State Hospital will be readmitted within 180 days of discharge.

Population: Adults discharged from the Arkansas State Hospital.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of discharges of adults followed by a readmission within 180 days of discharge from the Arkansas State Hospital.

Measure: Numerator: Number of discharges of adults followed by readmission within 180 days of the discharge. Denominator: Number of discharges of adults from the Arkansas State Hospital.

Sources of Information: Arkansas State Hospital Data System.

Special Issues: In order to be able to report 180-day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year (calendar 2007) rather than the most recent state fiscal year (2008) which serves as the time period for other indicator targets in this plan. Discharges include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded at some point in the future.

Significance: A hallmark of adequate aftercare with comprehensive community-based services is the ability to avert rehospitalization within an intermediate time period following discharge.

Action Plan: Maintaining a low rate of 180-day readmissions is accomplished by assuring prompt, appropriate, coordinated and ongoing aftercare. DBHS' contracts with CMHCs require that they make aftercare appointments available within two weeks of the date of discharge. The ASH social work department contacts each CMHC prior to a patient's discharge and arranges for this timely aftercare appointment. At the time of this contact, the ASH socal work staff also bring to the attention of the CMHC the individualized follow-up needs of the patient, including current medications and housing needs. ASH social work staff also assess the need for and make appropriate follow-up arrangements to respond to special client needs including, in particular, making referral for follow-up by an assertive community treatment (ACT) program or the other services of one of the three DBHS certified specialty Mental Health Clinic providers that focus on providing services to those with the highest level of service needs. In addition to timely and appropriate follow-up, sustained community tenure requires ongoing coordinated services which is accomplished through the system's extensive case management program.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Housing (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Supported Employment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Assertive Community Treatment (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	260	260	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the number of adults receiving Assertive Community Treatment (ACT).

Target: At least 260 adults will receive Assertive Community Treatment.

Population: SMI adults receiving ACT.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of adults receiving ACT.

Measure: Number of adults reported as receiving ACT.

Sources of Information: Special Services Program (SSP) Report.

Special Issues: The Special Services Program (SSP) report is a new aggregate (not client level) data report from all the state CMHCs inaugurated for SFY 2006. Prior to the SSP report, the number receiving ACT was obtained only through ad-hoc report requests to selected providers. However, the new SSP report does not have client level data with unique client identifiers so it is possible that the total served includes some duplication. DBHS continues work under its DIG grant to be able to produce an unduplicated count of the number receiving ACT and other EBPs.

Significance: Assertive Community Treatment is an evidenced-based treatment with proven effectiveness and efficacy in reducing rehospitalization in those at significant risk and in improving their community functioning.

Action Plan: DBHS was informed during the past SFY that one of the four ACT programs operated in the state discontinued operation due to a high level of staff turnover making impossible to maintain fidelity to the treatment model. DBHS is projecting that the other three operating programs will take up some of the slack created by the closure of this one program. DBHS will continue increased case rate funding to the GAIN program to prevent any reduction in the number of clients that can be served in that program. DBHS will continue to make available technical consultation to providers considering implementing ACT, in particular, consultation on Medicaid component billing for providing this service. DBHS will be systematically surveying and reporting on the implementation of all EBPs, including ACT, and making this data available to interested stakeholders, including CMHC boards, NAMI-Arkansas and AMHPAC.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Psychoeducation (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Illness Self-Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Medication Management (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	59.77	57	55	55	N/A	N/A
Numerator	309	278	--	--	--	--
Denominator	517	487	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the level of satisfaction with outcomes of service by adults receiving services of the public mental health system.

Target: Fifty-five percent of adults surveyed will rate satisfaction with outcomes positively.

Population: Sample of adults receiving public mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adults sampled that express positive satisfaction with outcomes of care.

Measure: Numerator: The number of adults surveyed who rated satisfaction with outcomes of care positively. Denominator: Number of adults surveyed who responded to survey items regarding satisfaction with outcomes.

Sources of Information: Statewide, random sample, completing the MHSIP consumer satisfaction survey.

Special Issues: Prior to 2005 this indicator was based on aggregated data from provider-administered convenience surveys, which varied in specific content among providers. DBHS has now instituted a statewide random sample survey using the MHSIP adult survey. As anticipated, scores using this new methodology are significantly lower than they had been prior to this new procedure being put in place

Significance: Achieving consumer-valued outcomes is the ultimate objective of a community-based system of care, and persons satisfied with outcomes of care are more likely to follow through with receiving needed services.

Action Plan: Although the new survey methodology, as anticiapted, is yielding lower satisfaction scores, it is the belief of DBHS that these new scores, based on a valid methology, will provide a more realistic basis for assessing the system's performance and planning improvements. DBHS is widely publicizing the survey results, including making them available in a consumer-friendly Report Card format and available through web-access. DBHS is also in the process of greatly expanding the survey sample size (for children's services in 2006 and adult services in 2007) so that in the future it will be able to produce individual organization level results. This will allow each provider organization to compare its performance with the state average and with other providers. These comparisons will then allow provider organizations to initiate focused quality improvements that it is anticiapted will lead to higher consumer satisfaction scores.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the percentage of consumers employed.

Target: DBHS will establish the percentage of consumers who are employed.

Population: Sample of adults being served by the public mental health system.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Mental Health Consumers Employed as a percentage of those in the Labor Force.

Measure: Numerator: Number of employed consumers
Denominator: Number of employed consumers plus the nubmer of unemployed consumers

Sources of Information: DBHS enhanced client-level database (SPQM).

Special Issues: The SPQM database has four file content options for the Employment Status Category: Employed, Unemployed, Not in Labor Force, Not Available. The calculation of this indicator will include only the first two options and will exclude the last two.

Significance: Employment is a frequently expressed consumer goal, yet unemployment rates, especially among those with serious mental illness, are high.

Action Plan: DBHS will use its new data system to establish the baseline for employment among clients of the public mental health system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Reduce criminal justice involvement of consumers in the public mental health system.

Target: Establish a baseline for decrease in criminal justice involvement.

Population: Sample of adult clients served in the public mental health system.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of adults sampled that reported decreased criminal justice involvement.

Measure: Numerator: The number of adults surveyed that reported decreased criminal justice involvement.
Denominator: The number of adults surveyed that responded to the criminal justice involvement survey items.

Sources of Information: Adult MHSIP survey with new items addressing criminal justice involvment.

Special Issues:

Significance: Reduced criminal justice involvement is one of the objectives of the public mental health system. Criminal justice involvement represents a failure of the system to provide timely alternative interventions.

Action Plan: DBHS is adding the criminal justice involvement items to the adult MHSIP survey and will be establishing a baseline for the rate of decrease of criminal justice involvement.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase housing stability among the clients of the public mental health system.

Target: Establish the baseline of consumers who are homeless or living in shelters.

Population: Clients of the public mental health system.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of consumer that are homeless or living in shelters

Measure: Numerator: Number of clients whose living status is Homeless/Shelter.
Denominator: Number of clients with a reported Living Situation.

Sources of Information: DBHS' new enhanced client level data system.

Special Issues: None

Significance: Increasing housing stability is one of the goals of the public mental health system and a special focus of its PATH grant. Homelessness adds to the stress individuals with serious mental illness experience and frequently adds to the difficulty in access needed services.

Action Plan: DBHS will use its new client level data system to establish the baseline of homelessnes (including living in Shelters) among clients of the public mental health system.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase social connectedness of clients of the public mental health system.

Target: Establish the baseline for social connectedness.

Population: Sample of adults receiving public mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adults sampled that expressed high levels of social connectedness.

Measure: Numerator: The number of adults surveyed that expressed high levels of social connectedness.
Denominator: The number of adults surveyed who responded to survey items regarding social connectedness.

Sources of Information: Adult MHSIP survey with new socal connectedness survey items.

Special Issues:

Significance: Improving social connectedness of clients is one of the objectives of the public mental health system and is one of the significant aspects of a recovery-oriented system.

Action Plan: DBHS is adding the social connectedness domain items to the MHSIP suvrey and will establish the baseline score for this domain.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the functioning level of clients of the public mental health system.

Target: Establish the baseline of improved functioning ratings.

Population: Sample of adults receiving public mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of adults sampled that rated themselves as having improved functioning.

Measure: Numerator: The number of adults surveyed who rated themselves as having improved functioning.
Denominator: Number of adults surveyed who responded to survey items regarding improved functioning.

Sources of Information: Adult MHSIP survey with new functioning level domain items added.

Special Issues:

Significance: Improved functioning is one of the primary objectives of the services of the public mental health system.

Action Plan: DBHS is adding the levle of functioning domain items to the MHSIP survey and will establish the baseline for scores in the domain.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Aftercare Appointments

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	90	93	85	85	N/A	N/A
Numerator	434	458	--	--	--	--
Denominator	482	493	--	--	--	--

Table Descriptors:

Goal: All persons being discharged from the Arkansas State Hospital will have timely access to aftercare services.

Target: 85% percent of adults being discharged from the Arkansas State Hospital will have an aftercare appointment scheduled within 14 days of date of discharge.

Population: Adults being discharged from the Arkansas State Hospital.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults discharged from the Arkansas State Hospital who have an aftercare appointment scheduled within fourteen days of date of discharge.

Measure: Numerator: Number of adults discharged from the Arkansas State Hospital who have an aftercare appointment scheduled within fourteen days of date of discharge. Denominator: Number of adults discharged from the Arkansas State Hospital.

Sources of Information: Arkansas State Hospital Social Work Department database report.

Special Issues: None.

Significance: Prompt aftercare reduces risk of rehospitalization and promotes community tenure.

Action Plan: Continue the practice of ASH social work department staff contacting the receiving CMHC prior to a patient's discharge and arranging for an appointment within 14 days of discharge. Monitor process on an ongoing basis and report annually. Note that this Indicator currently only monitors that an appointment is made. With its new enhanced data system, DBHS plans to begin tracking the rate at which aftercare appointments are actually kept and will explore the feasibility of modifying this Indicator to focus on the rate at which aftercare appointments are actually kept.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Community Services Funding

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	52	54	50	50	N/A	N/A
Numerator	36,000,000	38,619,994	--	--	--	--
Denominator	69,000,000	71,066,498	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the percentage of State Mental Health Authority (SMHA)-controlled funds available to community-based programs.

Target: At least fifty percent of the funds under DBHS' control will be devoted to community-based programming.

Population: Persons receiving public mental health services.

Criterion: 5:Management Systems

Indicator: Percentage of SMHA-controlled funds available to community-based programs.

Measure: Numerator: The total SMHA-controlled funds available to community-based programs.
Denominator: Total SMHA-controlled funds.

Sources of Information: SMHA financial management data system.

Special Issues: For SFY 05, DBHS made significant changes in the methodology for computing DBHS-Controlled Financial Resources. Medicaid funds, which are not controlled by DBHS, have been excluded in the calculation of both Community and Non-Community program budgets. In years prior to SFY 2005, the totals for Community Programs did not include Medicaid funding, which is not under the control of DBHS. However, Medicaid funds were included in the calculation of Non-Community Program Funding, even though these Medicaid funds are also not controlled by DBHS. The new methodology more accurately reflects DBHS' actual control of funds and its allocation priorities.

Significance: This percentage is a measure of the commitment of the SMHA to supporting and strengthening a community-based system of care.

Action Plan: DBHS will reflect in its future year budget requests to the Legislature the priority for supporting community-based services. DBHS will closely monitor legislative aciton on its budget requests. DBHS will allay with other stateholders, including CMHCs, AMHPAC, and NAMI-Arkansas to support legislative funding of community-based programing.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Off-site case management

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	57	54	50	50	N/A	N/A
Numerator	825,244	1,025,353	--	--	--	--
Denominator	1,458,067	1,907,948	--	--	--	--

Table Descriptors:

Goal: Provide case management services in an assertively responsive manner.

Target: At least 50% of case management units will be delivered off-site from the facilities of the community provider.

Population: Adults with a serious mental illness receiving case management services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of all units of case management that are delivered off-site from the facilities of the community provider.

Measure: Numerator: Number of 15-minute units of case management delivered off-site. Denominator: Number of 15 minute units of case management delivered both off-site and on-site.

Sources of Information: DBHS Enhanced Data Reporting System.

Special Issues: None.

Significance: Providing services off-site make them more accessible to clients and supports community integration.

Action Plan: DBHS will continue in its contracts with CMHC providers to require adhearance to established State Standards for CMHCs which includes the requirement for the CMHC to operate a Community Support Program and that, as needed, the program "takes services to the clients." DBHS will increase its monitoring and publication of the rate "off-site" intervention from semi-annually to monthly. DBHS will continue to advocate with Medicaid for payment to providers for services while transporting a client (as contrasted to payment for transporting a client which is paid for by Mediciad in a separate program).

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Satisfaction with Access

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	77	76	72	72	N/A	N/A
Numerator	417	395	--	--	--	--
Denominator	541	521	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the level of satisfaction with access to services by adults receiving services from the public mental health system.

Target: Seventy-two percent of adults surveyed will rate satisfaction with access positively.

Population: Sample of adults receiving public mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of adults sampled that express positive satisfaction with access to services.

Measure: Numerator: The number of adults surveyed who rated access to care positively. Denominator: Number of adults surveyed who responded to survey items regarding satisfaction with access.

Sources of Information: Statewide, random sample, completing the MHSIP consumer satisfaction survey.

Special Issues: Prior to 2005 this indicator was based on aggregated data from provider-administered convenience surveys, which varied in specific content among providers. DBHS has now instituted a statewide random sample survey using the MHSIP adult survey. As was anticipated the new methodology has produced significantly lower satisfaction scores.

Significance: Persons satisfied with access to care are more likely to follow through with receiving needed services.

Action Plan: Although the new survey methodology, as anticiapted, has yielded lower satisfaction scores, it is the belief of DBHS that these new scores, based on a valid methology, will provide a more realistic basis for assessing the systems performance and planning improvements. DBHS is widely publicizing the survey results including making them available in a consumer-friendly Report Card format and available through web-access. DBHS is also in the process of greatly expanding the survey sample size (for children's services in 2006 and adult services in 2007) so that in the future it will be able to produce individual organization level results. This will allow each provider organization to compare its performance with the state average and with other providers. These comparisons will then allow provider organizations to initiate focused quality improvements that it is anticiapted will lead to higher consumer satisfaction scores.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Services to Homeless

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	55	26	23	23	N/A	N/A
Numerator	1,628	762	--	--	--	--
Denominator	2,981	2,981	--	--	--	--

Table Descriptors:

Goal: Persons who are homeless and have a serious mental illness will have access to public mental health services.

Target: Twenty-three percent of the estimated SMI homeless adult population will receive services from the public mental health system.

Population: Adults with a serious mental illness who are homeless.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of homeless adults with a serious mental illness receiving public mental health services.

Measure: Numerator: The number of homeless persons with a serious mental illness who receive public mental health services. Denominator: The estimated number of homeless persons with serious mental illness.

Sources of Information: DBHS' Enhanced Data Reporting System.

Special Issues: Prior to SFY 2006, the number of homeless served data was based on reporting that did not have system-wide unique client identifiers, so it was not possible to calculate unduplicated counts of those served. The new enhanced data system, effective for SFY 2006, has system-wide unique client identifiers that allows the determination of the unduplicated number of homeless clients served. The amount of duplication in the years prior to SFY 2006 was unknown, and for this reason, the goal for SFY 2006 was to establish a performance baseline. DBHS initially set a target of 35% rate of serving the homeless population for SFY 2007. However, as anticipated in the 2007 application, after the SFY 2006 actual results were available it was necesary to seek a modification to its target in this area for SFY 2007 and reduce the target from 35% to 23%. This 23% target is continued for SFY 2008.

Significance: The homeless are an especially vulnerable and hard to reach population, and require special effort to assure access to services. The seriously mentally ill are at significant risk for homelessness.

Action Plan: DBHS will continue its competitive RFP process for awarding PATH grants so as to focus the use of these funds in the areas of greatest need. DBHS will continue to allay itself with other small states to seek an increase in federal PATH funding. DBHS will continue to dedicate at least half-time of a Division staff member's time to working on homeless issues. DBHS will increase its monitoring and publication of the rate of delivery of services to the homeless from semi-annually to monthly.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Services to Rural Population

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	1.31	60	51	N/A	N/A	N/A
Numerator	2	16,149	--	--	--	--
Denominator	1	27,065	--	--	--	--

Table Descriptors:

Goal: Maintain or expand access to mental health services for the population of adults with serious mental illness that reside in rural areas.

Target: At least 51% of the seriously mentally ill served will be residents of rural counties.

Population: Adults with a serious mental illness.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Percent of treated adults with a serious mental illness residing in rural counties as compared to percent of adults living in rural counties.

Measure: Numerator: Number of adults with serious mental illness served that reside in rural counties. Denominator: Number of adults with serious mental illness served system-wide.

Sources of Information: DBHS' Enhanced Data Reporting System.

Special Issues: Urban counties are those that are part of a Metropolitan Statistical Area. There are currently twelve such counties in Arkansas, and there are 63 rural counties. Per the 2000 census, 51% of Arkansas' adult population (1,015,512 of 1,993,031) reside in the 63 rural counties of the state. The target in this area is that at least the same percent of the serously mentally ill served will be residents of rural counties i.e., the service penetration rate for rural counties will be at least as high as that in urban counties. Note that, for ease of understanding, the manner is which this target is expressed is changed this year from previous years although the goal remains the same, i.e., the service penetration rate for rural counties will be at least as high as that in urban counties. The Actual SFY 2006 results shown above have been changed from the format used in the 2006 Implementation report to the new reporting format.

Significance: More than half of Arkansas' population resides in rural counties and it is important to continue to assure access to services to this population.

Action Plan: Maintain financial support for the public mental health system which, Arkansas being a rural state, was initially developed to serve this population. This support allows wide dispersal of service sites throughout rural areas of the state, extensive provision of transportation services, and provision of off-site services (separately monitored as a Block Grant Indicator). DBHS will increase its monitoring and publication of the rate of delivery of services to those in rural counties from semi-annually to monthly. DBHS will continue to advocate with Medicaid for payment to providers for services while transporting a client (as contrasted to payment for transporting a client, which is paid for by Mediciad in a separate program).

Arkansas

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 1: Comprehensive community-based mental health services
A. Establishment of System of Care

Current System

The public community mental health system in Arkansas is a statewide system of services, with service sites in 69 of Arkansas' 75 counties. In addition to providing services at its own sites, CMHCs provide services off-site in clients' homes, schools, community hospitals, jails and client job sites. In this manner, services are provided in all 75 of the state's counties. Services are provided through 15 comprehensive Community Mental Health Centers (CMHCs). In SFY 2006, the public community mental health system served approximately 66,545 mental health clients of which approximately 21,313 were children (some counted in both categories when they turn 18 during the year. All CMHC providers are private, not-for-profit agencies that provide services funded primarily through Medicaid and contracts funded by state general revenue. All have national accreditation through either CARF or JCAHO.

The fifteen private, non-profit community mental health centers in Arkansas provide direct care services through contract with the Division of Behavioral Health Services. These centers have assumed the leadership role in organizing and developing a full array of community-based mental health services for children. Children's services offered through the public mental health system include traditional out-patient services, assessment and plan of care, crisis stabilization intervention, on-site/off-site intervention, and rehabilitation day service and crisis intervention. Seven of the fifteen community mental health centers have therapeutic foster care programs for children and adolescents in state custody with serious emotional disturbance.

Other services available are case management, home-based services, as well as wraparound services and school-based and school-linked mental health services. Three community mental health centers provide psychiatric residential treatment services. One of these residential programs serves adolescents dually-diagnosed with substance abuse and mental health diagnoses. Specialized programs for children and adolescents are also available in some areas of the state such as alcohol treatment programs, both on an outpatient and inpatient basis, juvenile diversion programs, and supervision for juveniles discharged from the Youth Services Center.

The system also includes 34 private providers who must receive certification from DBHS before they can offer outpatient children's mental health services through RSPMI. They must also have national accreditation through JCAHO, CARF or COA.

The RSPMI Medicaid program funds the vast majority of mental health services for children. Lack of accountability in this program was cited in the report from Mr. Davis as being a major issue of concern. DBHS has made attempts to put more accountability measures in the system through proposing changes the DBHS certification process that is required prior to a provider

enrolling with Medicaid as an RSPMI provider. Unfortunately, those proposed changes have been blocked in legislative committees through efforts by a small number of providers. DBHS continues to work with legislators, providers, family members and community stakeholders to implement more accountability measures. Recommendations on this issue have been adopted by the Stakeholders Committee to be forwarded to the Children's Behavioral Health Care Commission. Hopefully this Commission can influence the legislative process in adopting better accountability measures for the children's mental health system.

DBHS is currently working with the DHS Director's office, legislators, families, providers and stakeholders to implement a revised policy addressing certification standards for all RSPMI providers. This policy was first submitted for public comment in November 2005 and has been revised numerous times but has not received approval through the legislative process. DBHS and DMS have significant concern about the lack of accountability regarding this Medicaid program but have encountered difficulty in the political process associated with making changes in the system. At this point, issues around children's behavioral health and the development of a system of care have been raised to the DHS Departmental level with great emphasis and support being placed on the improving accountability for how funds are spent and the quality of the services being purchased. A DHS Deputy Director has been assigned the task of leading this initiative. This has resulted in all child-serving DHS Divisions and the Department of Education/Special Education coming to the table to develop a system of care for Arkansas children.

Plan for Development of a System of Care

As reported in other sections of this application, a major initiative is underway in Arkansas to develop and implement a statewide system of care for children and adolescents. This initiative is a result of continuing escalation in costs for both inpatient and outpatient services. The primary issue of concern is that approximately 5,000 children were placed in bed-based care in SFY 2005 and then increased to almost 6,000 children in SFY 2006. This increase in bed-based care has occurred in spite of the fact that Medicaid expenditures for community-based care have more than doubled in the past four years. It is obvious that a major change in the system will be required to insure that children are receiving the appropriate level of services that is required to enable them to live with their families in their communities.

During the 2005 Legislative Session, Act 2209 was passed to create a Comprehensive Children's Behavioral Health System of Care Plan. A Children's Behavioral Health Plan Workgroup was formed to lay the ground work for development of a system of care for children with mental health needs and their families. In July, 2005 Memorandums of Agreement were signed between DBHS and the Department of Education/Special Education and all DHHS Divisions that serve children. A workgroup was established to review and research programs, expenditures, strengths and needs of the current system of care.

In November, 2005 Chris Koyanagi with the Bazelon Center for Mental Health Law met in Arkansas with DHHS Division Directors, Dept. of Education/Special Education Director, juvenile justice, legislators, parents and other stakeholders to provide an overview and guidance on the development process related to systems of care.

In February 2006, Cliff Davis, Human Services Collaborative, was hired as a consultant to provide Arkansas with an assessment of the current system and framework for systems development. His report was presented to the legislature in June 2006. A System of Care Stakeholders Planning Committee has been established to assist DHS in this initiative. Members of the Committee include parents and family, youth, community collaborators, advocacy, state agencies and other resources. This committee was instrumental in the development of SOC legislation addressing system of care issues in the 2007 General Legislative session.

Governor and First Lady Beebe supported the legislation, and have actively given their support through radio addresses, press conferences and the "Listening Tour" in which First Lady Ginger Beebe visited with families of children with serious emotional disturbances in 37 of the 75 counties in the state.

Cliff Davis, Consultant came to Arkansas in June 2007 to hold mini-trainings called "System of Care 101." These activities took place in 7 regions of the state with widespread participation from stakeholders, policy makers and providers.

The Annual Mental Health Institute is held in August of each year. Mental health consumers, family members, policy makers, providers and other stakeholders receive information pertaining to behavioral healthcare delivery, new treatment and service management technologies, and skills for effective diagnostic and treatment interventions. For the first time in the Institute's history, there will be a youth panel of consumers who will tell their stories and share from their perspective, better ways to serve them and other youth who may be in situations similar to that of their own. The conference also provides other pertinent workshops on children's issues. The Institute brings together over 1,000 mental health consumers, family members, providers, and policy makers from Arkansas and surrounding states.

A major emphasis will be placed on building family support and advocacy, and involving youth receiving mental health services in the decision-making processes within the mental health system.

Arkansas

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

2008 Mental Health Block Grant Application -Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 1: Comprehensive community-based mental health services
B. Available Services

Arkansas remains committed to building a mental health care system that supports the individual child and family's needs. The child's family should have access to a network of both formal and informal supports. The following support services are available in Arkansas.

Health, Mental Health and Rehabilitation

Each Community Mental Health Center (CMHC) provides the basic array of services to residents of the geographic mental health catchment area. These services include diagnostic assessment and treatment planning, psychological testing, medication management, individual and group psychotherapy, marital/family therapy and acute day treatment. Psychosocial Rehabilitative Services include community support, needs assessment and development of a plan of care, case management services including both on-site and off-site intervention, crisis intervention and crisis stabilization, psychosocial rehabilitative day services, collateral intervention involving consultation with other caregivers and persons involved in the client's life, and other rehabilitative and support services.

Medical and dental services are provided both in-house by CMHC employed nurses and physicians, or through referral to other community providers. For the Medicaid eligible client, these services can be accessed easily. For those without Medicaid or other forms of insurance, access to services are much more difficult. Case managers attempt to find free or reduced rate services for those without Medicaid.

Child and Adolescent Service System Program (CASSP)

The children's mental health system in Arkansas uses the CASSP model of an integrated system of care. Act 964 of 1991 established CASSP. Act 1517 of 2001 and Act 2209 of 2005 made revisions to the law to better meet the needs of children in our mental health system. The purpose for creating CASSP included the need for "a structure for coordinated policy development" and "comprehensive planning" in regard to children's mental health services in Arkansas. Specifically, an intention of this law is "to build on existing resources," as well as "design and implement a coordinated service system which is child and family centered and community-based." CASSP is based on values for an ideal system of care for mental health services for children and families. Many of the listed available services and resources have a representative on the CASSP Coordinating Council. Agencies and stakeholders, both public and private attend monthly CASSP Council meetings to plan and implement a coordinated system of care for children and adolescents with serious emotional disturbance and their families.

CASSP Regional Plans are revised and reviewed each even-numbered year by the CASSP Teams to identify and recommend program initiatives to the CASSP Coordinating Council, based on area and community-based needs. In addition, Act 2209 of 2005 designated the

Division of Behavioral Health Services (DBHS) as the state agency responsible for the coordination and oversight of a Comprehensive Children's Behavioral Health System of Care Plan. This legislation requires all state agencies to provide financial data regarding funds that support behavioral health services. Interagency agreements between DBHS and all other child-serving DHS agencies have been completed. Public and private stakeholders as well as parents and families will take part in the development and implementation of this plan. Having this comprehensive, collaborative approach to development of a plan for children's behavioral health services should decrease fragmentation and duplication within the system of care. The most effective component needed in the system of care is the ability to provide wraparound services that include nontraditional services such as respite, summer programs, and recreational programs including membership or attendance in Boys and Girls Clubs.

The state level CASSP Coordinating Council works from a Strategic Plan that identifies areas in the system that needs improvement. Members were assigned to workgroups to meet priorities in the following areas:

1. Build family support
2. Expand local capacity to collaboratively meet children's needs
3. Improve the quality of care
4. Public policy to positively impact children's mental health services.

Arkansas Rehabilitation Services (Employment)

The General Field Program provides a wide array of services designed to assist individuals with disabilities in obtaining and keeping employment. Federal, state, and local partnerships have been developed with public schools and interested individuals and agencies that serve persons with disabilities. The ARS Field Program operates 20 statewide offices for persons with physical, mental, cognitive or sensory disabilities. There are components within the rehabilitation system that provide specialized programs, such as transition services for students who are finishing school; services to help those who are presently receiving public assistance become employed, and therefore able to provide for themselves, and services for people with special communication needs.

Arkansas Department of Education

Arkansans have continually demonstrated a strong commitment to providing public education. DBHS and the Department of Education/Special Education continue to collaborate on school-based mental health services and other education/mental health issues. The Director of Special Education is on the System of Care Stakeholders Planning Committee.

The Special Education unit provides financial support to public agencies for the implementation of educational services, oversees the State's Comprehensive System of Personnel Development, provides technical assistance through consultation and professional development and manages the dispute resolution systems under the Individuals with Disabilities Education Act (IDEA) of 1997. Under this law, students are receiving an education in the least restrictive environment that includes evaluations, individualized education programs where parents and students participate in the decision making on the service plans and due process.

The unit developed the Arkansas Comprehensive System of Personnel Development program, which is a vital component of IDEA. ACSPD helps in assuring that all personnel serving toddlers, children and youth, birth to 21 years of age, are adequately prepared and trained.

To further address the IDEA requirements, the Division of Behavioral Health Services and the CMHCs have worked closely with the Department of Education Special Education Unit to develop and expand the School-Based Mental Health Network. The development of the School-Based Mental Health Network is supported by the ADE's willingness to promote professional accountability, without regard to student or family Medicaid or third party enrollment. Participation in the Network is based upon the guidelines summarized in the School-Based Mental Health Model. This model accentuates the importance of developing partnerships between schools, mental health agencies, and other community resources.

DHS Divisions and Offices Serving SED Clients In the Public Mental Health System:

Division of Child Care and Early Childhood Education

The Division of Child Care and Early Childhood Education (DCCECE) are responsible for the regulation and inspection of all child care facilities and home day care in Arkansas. It also oversees the Special Nutrition Program, the Arkansas Better Chance Program, offers staff support to the Arkansas Early Childhood Commission, and guarantees there is an educational component in childcare programs throughout Arkansas. DCCECE is providing funding for the public mental health system for training and three demonstration projects for early childhood mental health services.

Division of Children and Family Services

The Division of Children and Family Services (DCFS) protects children and helps preserve Arkansas families, through child protection services, intensive family services, juvenile services, adoption, foster care, and residential licensing. Currently, DCFS has agreements with all fifteen community mental health centers to provide mental health services for children on their caseload with specific requirements addressing accessibility and process for interagency communication.

Division of Health Services/Department of Health

On July 1, 2005, the Department of Health was placed under the Department of Health and Human Services as the Division of Health Services. The Hometown Health Improvement Project under the Department of Health brings together a wide range of people and organizations in the community to identify their health problems and develop and implement ways to solve them. On the local level this initiative stresses collaboration, coalition building, and community health assessment, prioritization of health issues and the development and implementation of community health strategies that are locally designed and sustained. On July 1, 2007, the Division of Health Services once again became the Department of Health.

Division of Medical Services
The Division of Medical Services (DMS) provides care through a network of providers to approximately 15% of the state's population through the Medicaid program and the Children's Medical Services program. The division provides a range of care from physician services to institutional care.

Division of Behavioral Health Services
The Division of Behavioral Health Services (DBHS) provides an integrated system of public mental health care to Arkansas residents. Services provided by this division are forensic psychiatric services, adolescent inpatient services, adolescent sex offender services, research and training. Comprehensive, contracted services are also offered by fifteen independent community mental health centers located throughout the state.

Division of Behavioral Health Services- Substance Abuse Services
Alcohol and Drug Abuse Prevention is under the Division of Behavioral Health Services. The mission of Alcohol and Drug Abuse Prevention is to help Arkansas citizens live productive lives, free from the abuse of alcohol, tobacco, and other drugs.

Division of Developmental Disabilities Services
Developmental Disabilities Services (DDS) helps people with developmental disabilities and their families in their homes, communities, or residential programs. The primary developmental disabilities are mental retardation, cerebral palsy, epilepsy, and autism. Among those services provided are diagnosis and evaluation, early intervention, case management, family support, residential care, and habilitation and education.

Division of Youth Services
The Division of Youth Services (DYS) protects public safety while helping youthful offenders choose productive lives and stay out of trouble by providing diagnostic and evaluation services for delinquent youth committed to DYS by a juvenile judge. It also provides residential treatment for youth that do not require serious offender programs and operates the serious offender program.

Other Support Services

Arkansas Mental Health Planning and Advisory Council (AMHPAC)
The Arkansas Mental Health Planning Advisory Council is set up by five regions. The total membership of the Advisory Council is 44, of which 8 of those members are family members of children with SED. There are 7 consumers, and other members who have special interest in children's services, and who also serve on the CASSP Coordinating Council, ASH Governing Board, System of Care committees and subcommittees, and the ACTION for Kids Board., the Governor's Integrated System Task Force, The Governor's Children's Behavioral Health Care Plan Commission and Disability Rights Center (PAMI)..

National Alliance on Mental Illness (NAMI) Arkansas

NAMI Arkansas, the state affiliate of the national organization of NAMI, is a non-profit, grassroots organization dedicated to improving the lives of those with mental illness by offering support, education and advocacy for them, their families and their communities. Further, the vision of NAMI Arkansas is to achieve an environment for mental health consumers and their families of quality, respect, equality, choices, acceptance, understanding, security and support.

Placing emphasis on accountability for services, effective service delivery and consistency of service delivery are priorities for NAMI Arkansas. Services may be medical, educational or rehabilitative. The organization believes that recovery and/or remission of symptoms is possible and it supports research and evidenced-based practice aimed at the prevention and cure of brain disorders. During this fiscal year, NAMI Arkansas will continue to provide the above services, including educational programs, outreach programs, support groups, information and referral services, advocacy and follow up with persons as necessary. Two toll free telephone lines and a local number will provide statewide help as necessary.

Mental health support, education and advocacy for children and their families has been a focus of NAMI Arkansas this past year. The organization's Executive Director has significant experience in the administration of children's mental health services, particularly in community-based mental health services. The focus of children and their journey of recovery from mental illness is one best traveled with their family. Early recognition, assessment and treatment are vital. Work thus far in the area of advocacy for children's mental health includes participation on the state and local CASSP (Child and Adolescent Service System Program) committees, participation on the System of Care workgroup committee, participation on the Action for Kids state governing committee and various talks/presentations to children in the community and/or their families. Work in this area will continue on behalf of children and their families.

Disability Rights Center

The Disability Rights Center is the Protection and Advocacy system and Client Assistance Program for people with disabilities in Arkansas. Each state and territory has a P&A and CAP responsible for pursuing legal, administrative and other appropriate remedies under federal and state statutes to protect the rights of individuals with disabilities. Investigation of allegations of abuse and neglect of persons with disabilities residing in facilities or in the community is another function. DRC, a nonprofit agency, is independent from state or local government. DRC focuses on broad areas of emphasis and develops priorities and objective each year in these areas. In general the DRC areas of emphasis are in education, abuse and neglect and quality assurance, employment, access to services, and community integration. During this current fiscal year, DRC is maintaining a presence in facilities and community programs for people with mental illness, developmental disabilities and other disabilities to monitor, investigate and attempt to remedy adverse conditions and situations. DRC is devoting considerable resources to advocate for access to inclusive educational programs, medical coverage, competitive employment, accessible affordable housing and restaurants.

Arkansas Advocates for Children and Families

The Arkansas Advocates for Children and Families will play a major role in the development and implementation of building family support aimed specifically at issues related to successfully raising children with serious emotional disturbances. This is a non-profit, non-partisan, child advocacy organization. As advocates, they research, educate, debate, dialogue, compromise and rethink children's issues. They perform an invaluable role for which most other people do not have the time, to create sounder public policies (laws) for Arkansas' children and their families.

Arkansas Federation of Families for Children'sMental Health

The Arkansas Federation of Families for Children's Mental Health has contracted with the ACTION for Kids SAMHSA funded children's initiative to provide consultation and training for the Family Support Network. The AFFCMH policy goals are to:

- Identify, define, and advocate for a policy agenda based on the experiences of children with mental health needs and their families
- Educate policy makers about issues affecting children with mental health needs and their families
- Develop family leadership capable of effectively participating in establishing and implementing public policies that produce better outcomes for children with mental health needs and their families.

Arkansas State Hospital

In addition to funding provided for community mental health programs, the Department of Human Services operates one State Hospital that has a 16-bed unit for adolescents, ages 13-17. Admissions are comprised of adolescents from all areas of the state. Community mental health centers have been designated as the single point of entry for adolescents being considered for admission to the Adolescent Inpatient Treatment Unit (AITU) of the Arkansas State Hospital.

Through single point of entry, these youth are required to be assessed at the community mental health center to determine the most appropriate and least restrictive level of care required. If admission to AITU is determined to be appropriate, discharge planning should begin at the point of admission with the local community mental health center's children's staff to provide for a smooth transition back to the home community when the youth is discharged. If an adolescent is screened for admission to AITU and hospitalization is deemed inappropriate, the community mental health center coordinates, in cooperation with other child-serving agencies/divisions, more appropriate services for the adolescent and family. While on the unit, both the adolescent and their families take part in their treatment.

The treatment plans are developed with the adolescent's input. They list their goals and go over the treatment plan and updates that assess their progress toward the goals thoroughly. When there is family involvement (which, unfortunately, is not the case for every child), the treatment plan is also discussed with them. Both the adolescent and family sign the treatment plan and updates. The treatment program for the Sex Offenders Unit is self-paced, with the adolescent

making all of the decisions about when he wants to work toward obtaining his next level in the level system.

In Arkansas, psychiatric hospitalizations for children are primarily funded through Medicaid and are provided by private hospitals. ASH has only a sixteen-bed adolescent program, that can be utilized as either acute care or longer term residential treatment. Due to the low number of adolescents hospitalized in the state-run facility, the number of readmissions to the ASH adolescent unit is not statistically significant. In addition, due to the fact that many adolescent admissions to ASH are considered "treatment failures" with a history of multiple hospitalizations in private programs, the population tends to be some of the most severely disturbed children in the state.

In an effort to move these adolescents to lesser restricted services in the community, the ASH adolescent unit has developed agreements with community providers that ASH will readmit for stabilization if those clients decompensate while in the community programs. This practice may increase the number of readmissions, but follows the goal to reduce hospitalization by reducing the number of days and lengths of stay for those children.

The Division of Behavioral Health Services, Arkansas State Hospital receives funding from the Department of Human Services to operate a 16 bed residential Sex Offenders Program for adolescents. There were 34% of the young men admitted to this unit who have graduated the program, 40% have been discharged due to no progress, and 26% have been discharged for various reasons, but were considered to have made some progress while in the program. DHS also contracts with private providers to provide residential and outpatient services to this population. These programs and others located throughout the state are utilized to decrease the number of children who are sent out-of-state for treatment.

Case Management System

Arkansas has targeted its system of care services, including case management to children with serious emotional disturbance and their families. To maintain and/or increase these services is a primary goal for us as well as of the mental health block grant law. The CASSP population subgroup should receive case management services because of their substantial use of public resources (funding and services), the complexity of their mental health and other service needs, and the benefit of case management in assuring desirable client-driven outcomes. Persons receiving substantial amounts of public funds include children and adolescents eligible for Medicaid, as well as those children in the child welfare system that have been diagnosed as having a serious emotional disturbance by a mental health professional at a community mental health center. Statistics show that approximately 21,313 children and adolescents receive services through a community mental health center. Case management services were provided to 9685 children and adolescents of the 16191 diagnosed with serious emotional disturbance through the CMHCs.

Since resources are not available to adequately serve the population of children falling within the SED guidelines, it is necessary to prioritize resources to subgroups of the population. DBHS and the community mental health centers will focus on serving children and adolescents within the target population who are at imminent risk of being removed from their families and those who

have been referred by community mental health centers to psychiatric hospitals, psychiatric residential treatment facilities, and therapeutic foster care programs. Currently, Therapeutic Foster Care (TFC) is the only evidenced-based practice that has been implemented in Arkansas on a statewide basis. Eight Centers report providing Therapeutic Foster Care to 311 clients in 166 Center operated Foster Homes, and one Center reports providing Functional Family Therapy to 22 clients. DBHS worked closely with the Medicaid system and the U-21 Utilization Management Company to develop a "care coordination" component of their services. This involves the expectation that all Medicaid recipients, who are hospitalized, whether in acute or residential facilities, will be referred to CASSP local service teams for the development of a multi-agency plan of services (MAPS) that requires family involvement.

Arkansas

Child - Transformation Efforts and Activities in the State in Criteria 1

Child - Describes mental health transformation efforts and activities in the State in Criteria 1, providing reference to specific goals of the NFC Report to which they relate.

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Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 1: Comprehensive community-based mental health services
C. Transformation Efforts and Activities

Recommendation 1.2: Address mental health with the same urgency as physical health.

Activities related to current efforts around building a System of Care for children/families with mental health needs has brought this issue into focus unlike any previous attempts that could be said to be with the same urgency as physical health. Act 1593 of 2007 establishes the principles of a system of care for behavioral health care services for children and youth as the public policy of the state.

DHS has oversight of activities on the state level to develop a statewide Comprehensive System of Care Plan for children and families in Arkansas with mental health needs. The Arkansas System of Care Stakeholders Planning Committee recently completed the task of making recommendations that will go to the Children's Behavioral Health Care Commission which was appointed by the Governor. These recommendations if adopted will become public policy for improving the effectiveness of behavioral health care and related services for children, youth and their families. There will also be better utilization and coordination of the state's behavioral health care resources devoted to serving children, youth and their families.

Governor Mike Beebe supported the legislation through radio addresses and press conferences. In addition, Arkansas' First Lady Ginger Beebe took on the challenge of a statewide "Listening Tour" with families in the state who have children experiencing mental health issues. The meetings were facilitated by families for families. The first lady and other stakeholders have met with approximately 100 youth/families in over 37 counties of the State. These events were sponsored by NAMI Arkansas and Arkansas Advocates for Children and Families, and were funded by DHS as a kickoff to building a statewide family network.

Arkansas

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 2: Mental health system data epidemiology
A. Estimate of Prevalence

Mental Health System Data Epidemiology

Arkansas' total population is 2.7+ million of which 25% are children and adolescents under the age of eighteen. The 2000 census data show that 80% of the population is white; 15.7% is black or African American; less than 1% is American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander, and; 3.2% is Hispanic or Latino. Over the years, Arkansas' Hispanic population has significantly increased. In 1990, the state total was 19,876 and in 2000, the total was 86,866-an increase of 66,990. U. S. Census figures indicate Arkansas' population is divided between 49% urban and 51% rural residents. There are 75 counties in the state-12 of which 12 would be considered urban and 63 considered rural. The per capita income was reported to be $19,595 in the 2000 census.

Estimate of the incidence and prevalence in the State of serious emotional disturbance among children ages 9-17, by State, 2006.

There are approximately 348,965 children and adolescents, age 9-17 in Arkansas. The estimated SED population for this group is calculated to be between 5-7% or 24,428 on the lower end and 31,407 on the upper end for children with a LOF of 50. With a LOF of 60, the estimated SED population is 9-11 percent of the number of youth 9-17 years old. The lower end is 37,919 children with the upper end of 44,813 children. The community mental health centers served approximately 21,313 children and adolescents during SFY 06, of which approximately 16,191 were diagnosed as SED. Analysis of Medicaid service utilization indicates that significantly more children in Arkansas are designated as SED, than what is expected according to national prevalence rates. This and other Medicaid usage for this population is currently under discussion by the System of Care Medicaid Workgroup.

The growth in the minority population has mostly come from the Hispanic community. In an attempt to overcome barriers which have surfaced in the formal mental health system, efforts have been focused on trying to increase hiring of minorities in the local community mental health centers when there are job openings and encouraging client use of the network of natural support systems such as extended family members, friends, churches, and self-help organizations. The goal is to provide services that are culturally sensitive and responsive to the special needs of these children and families. The SOC Planning Committee has a Cultural Competency Workgroup that will be making recommendations to the Children's Behavioral Health Care Commission who will provide advice and guidance to DHS and other state agencies providing behavioral health care services to children, youth and their families. The mental health system should encourage, on both the state and local levels, early educational opportunities for children and eliminating any disparities in availability and access to mental health care. An

ethnic minority representative serves on the CASSP Coordinating Council, and the Council has provided cultural diversity presentations to its members. The community mental health centers provide in-service training on cultural issues as a part of their staff orientation. In addition, the Annual Mental Health Institute agenda as a practice include sessions on cultural diversity issues. In rural Arkansas, the Community Mental Health Centers have increased services to the rural population and minorities through their school-based mental health programs, after school and summer programs. They have found that the demand is much greater than the financial and human resources that are available in most areas of the state.

Data-Management, Reporting, and Analysis System

DBHS currently collects both client-level and aggregate-level data from the community mental health centers. The client-level data does not contain a unique identifier, so it is not possible to produce unduplicated counts of clients served. The aggregate data collected does provide information for tracking many aspects of the systems' functioning, but also does not have unique client identifiers and does not permit a breakdown of data into desired subcategories. Client satisfaction data is only available through the aggregate data collection system and the instruments used in the surveys vary among the community mental health centers. During the past several years, in part with funds provided through the SAMHSA Data Infrastructure Grant (DIG), DBHS has contracted with a private vendor to collect, store and report system wide client and service data. Since SFY 2004, the aggregate collection of adult and child data has been completely integrated and a previous separate data collection system for children's data has been eliminated. The system operates through a secure encrypted web-based application. It includes unique client identifiers which will allow determination of unduplicated counts served, allow the linking of client data with service data, and enable the tracking of clients across the system including as they move from community-based care to treatment in the Arkansas State Hospital and vice versa. Client satisfaction surveying is also being significantly improved over the aggregated, CMHC specific system described above. With input from system stakeholders, DBHS decided to use the SAMHSA recommended MHSIP adult and child/family surveys with the addition to each of items of local interest. A random sample of child/family clients was drawn. Surveying indicates the following:

Child/Adolescent Consumer Survey Results	Number of Responses	Number of Positive Responses	Confidence Interval
1. Reporting Positively About Access	3466	2702	78%
2. Reporting Positively About General Satisfaction for Children	3483	2411	69%
3. Reporting Positively About Outcomes	3464	1911	55%
4. Family Members Reporting On Participation in Treatment Planning for their Children	3460	2611	75%
5. Family Members Reporting High Cultural Sensitivity of Staff	3468	3021	87%

The results for 2006 CMHC Client Satisfaction Survey items show scores significantly above or below the state average. These have been made available to stakeholders in a number of formats, including a consumer-friendly "Report Card" and web-accessible reports.

Arkansas

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 2: Mental health system data epidemiology
B. Quantitative Targets

Mental Health System Data Epidemiology

DBHS will continue to monitor the public mental health system in terms of providing services to its target population of children and adolescents with SED. The goal is to use the Comprehensive System of Care Plan to guide the Department of Human Services in transforming children's behavioral health in Arkansas.

The enhanced data system has system wide unique client identifiers that will allow the determination of the unduplicated numbers of clients served. The amount of duplication in the previous counts reported is unknown and, for this reason, the goal for this plan is to provide more accurate estimates on the unduplicated number of children and adolescents with SED that were served by the community mental health system. The public mental health system will determine the unduplicated number of clients served in the state's public mental health system to establish data on service penetration rates based on this unduplicated count.

Arkansas

Child - Transformation Efforts and Activities in the State in Criteria 2

Child - Describes mental health transformation efforts and activities in the State in Criteria 2, providing reference to specific goals of the NFC Report to which they relate.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 2: Mental health system data epidemiology
C. Transformation Efforts and Activities

Recommendation 2.1: Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Each CMHC is held to standards/policy that is put in place by the State, and National accreditation standards such as CARF, JCAHO, or COA are required for RSPMI certification. These standards require that individualized plans of care are completed and approved by the client. Further, through the CASSP process for children/families, local service teams which includes the family, identify service needs through joint, collaborative planning with the local team members, and their representatives, utilizing a multi-agency plan of care (MAPS) to address the services currently received, resources previously pursued, plan for immediate and long-term needs and designation of tasks to be completed.. This meeting does not take place if the parent/guardian is not present for the staffing. The number of children, families, other agencies and organizations involved in the MAPS staffing are reported quarterly to DBHS.

Recommendation 2.2: Involve consumers and families fully in orienting the mental health system toward recovery.

Within DHS, DBHS staff is active in advocating for the public mental health system and bringing its expertise to the table, with other DHS Divisions, such as the Division of Developmental Disabilities, Division of Family and Children Services and Division of Youth Services. Staff of DBHS meets frequently with staff of these other DHS Divisions involved with providing public human services, many of which have mental health components.

Through the leadership and advocacy of the Arkansas Mental Health Planning and Advisory Council (AMHPAC) DBHS and other System of Care stakeholders have recognized the importance of having children and families involved in a system that is moving toward recovery. DBHS staff meets regularly with this Council, and fully involves them for input to the staff that prepares the Block Grant Application. The SOC legislation emphasizes that mental health care should be family-driven, youth-guided and child-centered. The promotion of this language has been verbalized to policy makers, service providers and other agencies/organizations that are involved in children's mental health services. DBHS realizes that parents and caregivers should be viewed as experts about their children, and have final choice about the types and mix of services they receive. The System of Care should ensure that comprehensive mental health assessments are done, when indicated, before service planning processes identify child and family strengths and match flexible services and supports to those strengths to address child and family needs. Child and family feedback should be elicited and constantly used to adjust services and supports, aimed at maximizing positive outcomes for children. A model for this commitment is the ACTION for Kids initiative that is funded through SAMHSA, and is

operating in 4 counties of the Delta region in our State. This model will hopefully be duplicated statewide if there are positive outcomes from this intervention.

During the months of May-June 2007 the State's First Lady, Ginger Beebe, began a statewide "Listening Tour" with families in the State who have children experiencing mental health issues. The first event was a Children's Mental Health Summit. Parents and youth who have been diagnosed with a mental illness were invited to attend. The First Lady used these forums to reach out to families at lunches, brunches, potlucks and other events across Arkansas that were organized by the CMHCs in the local community. These events were sponsored by NAMI Arkansas and Arkansas Advocates for Children and Families, and were funded by DHS as a kickoff to building a statewide family network.

Aimed at reducing stigma for youth, the 35th Annual Behavioral Health Institute held in August of each year, will for the first time in the Institute's history, present a youth panel of consumers who will tell their stories and share from their perspective, better ways to serve them and other youth who may be in situations similar to that of their own.

Recommendation 2.4: Create a Comprehensive State Mental Health Plan.

In addition to the Mental Health Block Grant Application, several legislative initiatives have been passed that will help in the creation of a Comprehensive State Mental Health Plan. Act 2209 of 2005: An Act to Create the Comprehensive Children's Behavioral Health System of Care Plan. This law provided increased representation of private providers on the CASSP Coordinating Council. It also designated DBHS as the state agency responsible for the coordination and oversight of a Comprehensive Children's Behavioral Health System of Care Plan. All state agencies that receive funding, either state or federal, that supports behavioral health services, were mandated to participate in collaborative planning for the system of care. It required that in July, 2005, collaborative agreements were to be established between DBHS and all other state agencies regarding responsibilities for the development and implementation of the System of Care Plan. It also required that all agencies provide all pertinent information to DBHS, including expenditures and programming data that was necessary to develop the plan. As reported in Section I.3, this legislation has resulted in a DHS Departmental Initiative.

Act 1593 of 2007: A follow-up to Act 2209 of 2005. This legislation establishes the principles of a System of Care for behavioral health care services for children and youth as the public policy of the State; for improving the effectiveness of behavioral health and related services to children, youth and their families, ensures better utilization and coordination of the States' behavioral health care resources devoted to serving children, youth and their families. The legislation also addresses the Children's Behavioral Health Care Commission has been established by the Governor to provide advice and guidance to the Department of Human Services and other state agencies providing behavioral health care services to children, youth and their families on the most effective methods for establishing a System of Care approach.

Arkansas

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

2008 Mental Health Block Grant Application - Arkansas
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
1. Current Activities-Child
Criterion 3: Children's Services
A. System of Integrated Services

Below are listed services and programs that are involved in current system activities. Stakeholders involved in the current system are also participating in committees and workgroups that have been established to develop a Comprehensive System of Care Plan for behavioral health care services in Arkansas.

Child and Adolescent Service System Program (CASSP)

In 1991, Act 964 was enacted establishing the Child and Adolescent Service System Program (CASSP) in Arkansas. The purpose of the Act is to establish a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services to children with emotional/mental disorders and their families. It is further the intention of Act 964 to build on existing resources, and to design and implement a coordinated service system that is child and family-centered and community-based. Act 964 also established a CASSP Coordinating Council, which includes 44 representatives from State agencies and local providers of services to the target population, as well as family members, and child advocates. The Council has met quarterly since July 1991 for the purposes of providing specific guidelines for the development of regional services and plans based on the guiding principles of the CASSP system of care and for review and approval of regional plans developed by CASSP Regional Teams and incorporation of the Regional Plans into the Statewide Children's Mental Health Plan. The CASSP legislation was revised in 2001 and 2005 to better reflect what is actually happening in children's mental health services in Arkansas. The 2005 legislation required the creation of the Comprehensive Children's Behavioral Health System of Care Plan that will be developed and implemented with representatives of all state agencies receiving funding, either state or federal, and other stakeholders, including the private provider sector. Legislation was also passed in the 2007 General Session that establishes the principles of a system of care for behavioral health care services for children and youth as the public policy of the State.

Together We Can

In its commitment to an integrated service system, the Department of Human Services' Director's Office has renewed the grant to the divisions to work collaboratively on the "Together We Can" project, which is based on CASSP principles. There are currently 36 counties that are approved to provide "Together We Can" wraparound services. Funds are used for individuals and their families to preserve the family unit and enable the individual to function in his/her home environment and community. The participating agencies meet the needs of this population through individualized, coordinated, multi-disciplinary interagency processes, sharing cost and expertise. In some counties, TWC and CASSP work together on children and adolescents who meet the criteria of both programs.

ACTION for Kids

Arkansas is joining the nationally approved way that services are delivered to children and their families with serious emotional disturbance. SAMHSA has funded a site for a System of Care initiative in four counties in the eastern Arkansas Delta region. This collaborative has been a catalyst for change to a family-driven, youth-guided, child-centered System of Care that offers wraparound services, flexible funding, and care coordination. The goal is to replicate this project statewide.

Early Childhood Mental Health

The Division of Childcare and Early Childhood Education (DCCECE) and the Head Start Collaboration Project continue to work with DBHS to promote early childhood mental health services. DCCECE is currently funding three demonstration projects, training and conference calls for the early childhood liaisons from the demonstration projects and other CMHCs to increase expertise in community mental health centers on a statewide basis.

Substance Abuse

The Division of Behavioral Health Services-Alcohol and Drug Abuse Prevention's policy and philosophy is that the most effective services are community-based and community-supported. They contract with local programs to establish an effective network of services. The area that helps children and adolescents most is the Prevention, Education and Early Intervention Unit. ADAP uses approximately twenty (20%) percent of the Substance Abuse Prevention and Treatment Block Grant funds for the alcohol, tobacco and other drug abuse prevention programming, which includes the U-21 population.

The ADAP funds thirteen regional Prevention Resource Centers to provide ATOD prevention programming services necessary to facilitate community empowerment in addressing these issues. In addition to prevention programming utilizing Substance Abuse Prevention and Treatment Block Grant funds, prevention programs are administered using the Governor's portion of Safe and Drug-Free Schools and Communities Act funds.

Through funding from ADAP, one of the community mental health centers operates a 24-bed residential adolescent chemical dependency treatment program. Horizon utilizes a strong multi-disciplinary approach in the treatment of chemical dependency and concomitant psychiatric problems for youth ages 13-18. ADAP also funds Dunston Adolescent Treatment Center, a 12-bed treatment program for male and female adolescents with chemical dependency. Other programs with funding through ADAP can treat adolescents 16 and above on an outpatient basis.

Juvenile Services

The Division of Youth Services serves the juveniles of Arkansas who have either come in contact with the judicial system or are in danger of coming in contact with the judicial system.

To accomplish this end, The Division of Youth Services (DYS) moved toward small wilderness programs for serious offenders and community-based alternatives to incarceration. The community-based programs teach life skills and improve educational levels to help juvenile offenders before their offenses escalate.

DYS is also building on a system of community providers to divert juvenile offenders to day treatment, therapeutic group homes, electronic monitoring, and independent living and restitution programs in their own communities. DYS, DBHS, and the CMHC's have worked on strengthening their relationships to better serve the mental health populations who are adjudicated through the juvenile court system. DYS also utilizes Medicaid funds to provide mental health services to their population, through a rehabilitation option waiver.

Four of the 15 CMHC's contract with DYS to provide community-based youth services programs for adolescents. These programs provide the following services: targeted case work management, therapy, diagnosis and evaluation, intensive case work management, intensive casework management-serious offender, interstate compact and residential treatment. In addition, the community-based providers provide emergency shelter and sanction services that included restorative justice, intensive supervision and tracking, compliance monitoring, drug screening, day services and crisis residential treatment.

DYS contracts with a private company to manage the Alexander Youth Services Center. This facility serves a population of both male and female juveniles committed to the department on felony and misdemeanor offenses. There have been serious issues with education, mental health services and client safety at this center. Recently, they have been investigated by the Justice Department, and the state Disability Rights Center. There are a total of 139 beds for committed juveniles. Of these beds, 18 are for females and 121 for males. The intake and holding population includes juveniles who are sex offenders, juveniles requiring psychiatric intervention and juveniles with serious behavior problems. They are housed in the facility until appropriate placement is available.

Senate Resolution (SR) 31: Requested a study of ways to improve the State's juvenile justice system for youth committed to the Division of Youth Services of the Department of Health and Human Services.

Act 643 of 2007: This act requested that the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth study the Juvenile Justice System regarding juveniles who have been committed to the Division of Youth Services or who are otherwise being detained in Juvenile Detention Centers.
The CASSP Coordinating Council has recently established a JDC/Mental Health Committee to explore how mental health services are provided to the youth population confined in the 14 juvenile detention centers across the State.

The federal Medicaid standard making children ineligible for service reimbursement upon entry into a correctional facility places the treatment burden on the shoulders of the counties. The counties tend to operate on a tight budget, often with little or no funding for the juvenile to receive or continue treatment. Some manage better than others. The committee is comprised of

detention facility directors, legislators, mental health providers, and Youth Services personnel. The goal of this committee is to make recommendations to the legislators on the Interim Study Committee, the System of Care Planning Committee, and the CASSP Coordinating Council that could result in sweeping changes in the juvenile detention centers, and juvenile services as a whole. This endeavor has also led to better communication and collaboration with juvenile services personnel.

DBHS' enhanced data system went online July 1, 2005. It has been referenced and described in several other sections of this plan. This system permits better monitoring of system performance, including revealing aspects of the system that could benefit from quality improvement initiatives. The enhanced system will allow tracking of the results of these initiatives.

Mental Health Needs of the Child Welfare Population

Due to the prevalence of mental health issues for the child welfare population, emphasis has been placed on developing services to meet the special needs of this vulnerable target group. The Arkansas Department of Human Services Division of Children and Family Services (DCFS), through grants and state general revenue, help families avoid unnecessary out-of-home placement of their children, reunite children who have been previously placed, or provide support to permanent alternate living arrangements such as adoptions. According to the comprehensive assessment done within 90 days of entering care, ninety percent of foster children school age and above are referred for mental health services.

DBHS began planning initiatives with DCFS to help meet the mental health needs of this vulnerable population. A letter of agreement between DCFS and the CMHC's address timeliness of mental health services, as well as the functions and responsibilities of each agency.

The Behavioral Treatment Unit provides technical and financial assistance to local county offices requiring assistance in locating and/or funding out-of-home placements for children in the custody of DHS who are experiencing emotional and/or behavioral problems. The Division provides these placements through contracts with private providers or Medicaid providers. Services purchased include therapeutic foster care. DCFS has also worked with five of the CMHCs on a Single Point of Entry (SPOE) pilot project involving the therapeutic foster care population. In addition, DCFS has a mental health liaison that serves on the CASSP Coordinating Council, the SOC Planning Committee who participates in CASSP site visits and other collaborative efforts on children's mental health issues.

Arkansas Department of Education-Special Education

The Special Education Unit is responsible for the oversight, administration and implementation of educational services for all eligible students with disabilities, ages 3 to 21. The unit is responsible for working with public and private agencies involved in the education and financing of educational services for this population.

The unit provides financial support to public agencies for the implementation of educational services, oversees the State's Comprehensive System of Personnel Development, provides technical assistance through consultation and professional development and manages the dispute resolution systems under the Individuals with Disabilities Education Act (IDEA) of 1997. Under this law, students are receiving an education in the least restrictive environment that includes evaluations, individualized education programs where parents and students participate in the decision making on the service plans and due process.

The unit developed the Arkansas Comprehensive System of Personnel Development program, which is a vital component of IDEA. ACSPD helps in assuring that all personnel serving toddlers, children and youth, birth to 21 years of age, are adequately prepared and trained.

To further address the IDEA requirements, the Division of Behavioral Health Services and the CMHCs have worked closely with the Department of Education Special Education Unit to develop and expand the School-Based Mental Health Network. The development of the School-Based Mental Health Network is supported by the ADE's willingness to promote professional accountability, without regard to student or family Medicaid or third party enrollment. Participation in the Network is based upon the guidelines summarized in the School-Based Mental Health Model. This model accentuates the importance of developing partnerships between schools, mental health agencies, and other community resources.

The number of children identified as emotionally disturbed under The Education for the Handicapped Act P.L. 94-142, is very low compared to the national average, with 788 children and adolescents ages 6-21 and one child (5 year old in kindergarten), identified statewide through the 2005 Child Count. According to Arkansas education officials, this low identification rate can be attributed to several factors: 1) few specialized services are available for children with serious emotional disturbance; 2) significant delays are experienced in completing evaluations of children referred for P.L. 94-142, further diminishing the motivation to identify children as needing special education certification; and 3) limited federal funding subsidies to cover the increased costs for special education services. An assessment specialist with the Department of Education/Special Education assists local school districts in serving students.

Examples of two Special Education interventions that are offered to parents and their students with special needs are:

<u>Post-School Outcome Interventions for Special Education (POISE)</u>
The State is using staff funded through Title VI-B set-aside dollars to offer student-specific interventions. The staffs are accessed through the Special Education website request for services process known as CIRCUIT. The IDEA authorizes State activities to Local Education Agencies, including direct and supportive service activities, to improve results for children with disabilities, ages 3-21, by ensuring a free, appropriate public education in the least restrictive environment. For this purpose, a regional cadre of special education consultants is available who can assist in interventions for students with sensory disabilities, multiple physical disabilities, behavior, and autism spectrum disorders. Services can be requested by parent, guardians, caregivers, school personnel, or any other concerned party.

Centralized Intake and Referral/Consultant Unified Intervention Team (CIRCUIT)

The IDEA of 2004 (Public Law 108-446) authorized activities to Local Education Agencies, including direct and supportive service activities results for children with disabilities, ages 3-21, by ensuring a free, appropriate public education in the least restrictive environment. For this purpose, a regional cadre of special education consultants is available who can assist in interventions for students with disabilities. Services can be requested online. A CIRCUIT resource will do follow-up with the referring person within two working days. It is anticipated that CIRCUIT will provide school personnel and parents with an easy access process to obtain support for students with disabilities at risk of dropping out.

Disability Rights Center

The Disability Rights Center advocates for children with disabilities in Arkansas. A DRC attorney is a member of the CASSP Coordinating Council. Their priorities under children's issues for 2006 were:

1. Unlawful exclusion (suspension, expulsion or exclusion from school in violation of IDEA).
2. Students with behavioral issues will receive mental health or personality evaluations to assist in programming.
3. Students with a mental health diagnosis will be referred to the Child and Adolescent Service System Program (CASSP).
4. Least restrictive environment (does the school offer the continuum of placement options from instruction in regular class, resource, self-contained, school-based day treatment, special day school, residential school, hospital instruction or homebound instruction).
5. Students with disabilities in the juvenile detention facilities will receive special education services.
6. Increase awareness of birth through five programs through the use of fliers, posters and workshop presentations.
7. Students will be referred for assistive technology evaluations.
8. Students will be referred for assistive technology devices or services; and
9. Distribute the revised blue books after the IDEA regulations are published.

Department of Health

The Department of Health's Hometown Health Improvement Project brings together a wide range of people and organizations in the community to identify their health problems and develop and implement ways to solve them. This locally controlled initiative stresses collaboration, coalition building, and community health assessment, prioritization of health issues and the development and implementation of community health strategies that are locally designed and sustained. The Department provides preventive health services under the Office of Disabilities Prevention (ODP). They promote the elimination of barriers for all persons with disabilities throughout Arkansas, in partnership with other state, local, and community agencies, and persons with disabilities and their families.

The MCH Block Grant makes funds available to the state of Arkansas: 1) to assure quality maternal and child health services to mothers and children (targeting especially the low income families; 2) to reduce infant mortality and the incidence of preventable and handicapping diseases; 3) to provide rehabilitation to children age 16 or below who are blind and disabled; 4) to locate and provide care for children with special health needs. Currently, the Division of Child Care and Early Childhood Education is implementing a maternal child health grant that focuses on social and emotional well-being of young children and utilizes a multi-agency approach for the planning and implementation for a system of care for young children. On July 1, 2005, the Department of Health became the Division of Health Services under the Department of Health and Human Services. July 1, 2007, the two departments "de-merged" and again are the Department of Human Services and the Department of Health.

The Department of Health has participated on the System of Care workgroup that was formed to develop priorities for the Comprehensive System of Care Plan that the Department of Human Services is currently working to implement.

Arkansas

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

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Criterion 3: Children's Services
B. Geographic Area Definition

Defined Geographic Area

The defined geographic area for the provision of comprehensive community mental health services for children with a serious emotional disturbance is the State of Arkansas. The system provides children's mental health services through 15 private non-profit community mental health centers. Each community mental health center is responsible for the provision of services in a geographical area defined by counties, and has a defined CASSP Regional Team within each mental health center catchment area populated. Through the CASSP Regional Team process, each "community" is allowed the flexibility to develop and expand services in ways that reflect local needs and existing resources.

Arkansas

Child - Transformation Efforts and Activities in the State in Criteria 3

Child - Describes mental health transformation efforts and activities in the State in Criteria 3, providing reference to specific goals of the NFC Report to which they relate.

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C. Transformation Efforts and Activities

Recommendation 4.1: Promote the mental health of young children.

The DBHS has led the effort to expand services aimed at early identification and treatment for the needs among younger children before those needs escalate to a level of "severe" disturbance. Three early childhood projects were again funded to encourage community mental health centers (CMHCs) to develop more expertise at working with young children. This effort has required the building of new collaborative partnerships with several types of expertise such as pre-school and day care providers, Head Start programs, pediatricians, family physicians and other public health entities.

Recommendation 4.2: Improve and expand school mental health programs.

School-based Services have been developed and expanded through partnerships between the community mental health centers and school districts with some funding from the Division of Behavioral Health Services. These initiatives have proven to have positive outcomes for the children and the schools involved. Some community mental health centers in collaboration with the Department of Education have also joined a network of providers to do evidence- based school-based mental health services. SOC implementation goals include policy changes in school-based services that will result in greater accountability and consistency in the program. The Division of Behavioral Health Services has worked closely with the current utilization management system to improve services for the U-21 Medicaid population and insure that outcomes are consistent with the CASSP and SOC principles. Care Coordinators have been utilized in the community to work closely with each community mental health center to prevent children in need of services from falling through the cracks. Many of these children are referred for individualized staffings through the CASSP process.

Arkansas

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

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1. Current Activities-Child
Criterion 4: Targeted services to rural and homeless populations
A. Outreach to Homeless

Homeless Population

Using the latest census data, it is estimated that approximately 12,000 or more individuals can be described as being homeless "on any given night" in Arkansas. Of this number, approximately 4,320 or 36% are children. An estimated 2,160 homeless children are SED, but only a fraction of these children are seen by the CMHCs. The Division of Behavioral Health Services is the recipient of Projects for Assistance in Transition From Homelessness (PATH) Grant. The State of Arkansas receives $300,000 in funds each fiscal year. DBHS distributes PATH funds through a competitive basis to CMHCs who serve mental health clients. DBHS, including staff from children's services, conducted site visits with the CMHCs that received funding.

Arkansas is participating in the Policy Academy on Improving Access to Mainstream Services for Homeless Families with Children. DBHS, along with eleven other state and private agencies, have been involved in the development of a strategic action plan for improving access to mainstream resources for homeless families with children and unaccompanied homeless youth. This plan was submitted in June, 2005 and outlines actions, expected outcomes, and benchmarks that are to be completed within the next two years by the policy Academy Team. In 2006, the adult and children's Policy Academy merged. Meetings now include both groups working together on homeless issues.

DBHS will be involved in developing an inventory of available behavioral health services and service needs for this population and promoting the development of necessary services to address gaps in the service continuum in the various regions of the state Efforts are being made to better assess the gaps in services, as well as improve them, for the homeless population. The Interagency Council for the Homeless, of which the Division of Behavioral Health Services is a member, sponsors an annual conference addressing homeless issues. This year's conference will be held in October 2007.

Through the Emergency Shelter Grants Program, Emergency Community Services Homeless Grant Program, PATH, Mental Health Block Grant, Adult Education Homeless Program, Education for Homeless Children and Youth Program, Emergency Food and Shelter Program, Continuum of Care activities, Temporary Emergency Food Assistance Program, Food Stamps, Supplemental Assistance for Facilities to Assist the Homeless, and the Veteran Domiciliary Care Program, many of these special needs of the identified homeless population, such as families with children, and people with mental illness and emotional disorders are being addressed. It is our goal to increase the number of homeless children and families receiving services through PATH and other resources.

In September 2006, a homeless outreach event was sponsored by the Arkansas Policy Academy as well as local, state and federal government agencies, businesses, and faith-based and non-profit organizations. Trained professionals offered medical, dental, and eye examinations and mental health screenings. Participants also received information on housing, job readiness, shelters, mental health and substance abuse services.

Grants have been awarded to school districts throughout the state under the McKinney-Vento Homeless Assistance Act. The definition of Homeless Youth includes an individual who lacks a fixed, regular and adequate place of residence. The Department of Education has developed linkages among providers by linking homeless service liaisons in schools to the state Health Management Information System. There is also training provided in school districts to remove enrollment barriers and to improve access to community resources. School districts will also be surveyed to determine the number of children who are homeless that they are serving.

All participating local educational agencies (LEAs) are authorized to provide and implement services and activities which include services to ensure that homeless children and youth enroll and succeed in school. Education and training programs are offered to parents of homeless children and youth regarding the rights their children have as homeless individuals and the educational and other resources available. While some of the obstacles faced by this population have been addressed by school districts, barriers to the enrollment, attendance and success of these children in school persist. The goal is to do a better job with identification, outreach and support.
Barriers include:

- lack of identifying homeless students within the district;
- difficulty in obtaining prior school and health records;
- school district misinterpretation of residency issues, guardian issues;
- risk of danger to children fleeing domestic violence.

Arkansas

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

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Criterion 4: Targeted services to rural and homeless populations
B. Rural Area Services

Rural Population

Arkansas' public mental health system serves a large rural population. Arkansas has 12 counties that are considered urban and 63 that are considered rural. The system currently provides services in different service sites in 69 of the 75 counties. The counties without service sites are very sparsely populated. The system will either transport children to service sites, if needed, or make services available at the child's home and/or school. In our small rural counties, a major problem affecting care is lack of adequate transportation. This includes lack of public transportation, poor roads, extremely long distances to services, and a lack of economic means to have private transportation. Many consumers live in very isolated places with no telephones. In some cases, the family's use of informal supports such as neighbors, friends and other family members, is common.

The CASSP teams recognize the need for more staff at both the professional and paraprofessional level to work with children in rural areas of the state, and with minorities. However, it is often very difficult to recruit professionals to go into rural areas. While a lack of staff and financial resources is seen as a barrier, mental health providers in small communities feel they have a good working relationship with other community agencies. Reasons given for this collaboration includes the fact that they often see each other at community functions and events away from the work place. They often work together to provide what is needed for their community with limited resources. Providers and their staff usually have a good working knowledge of existing community resources. Rural counties report having a number of volunteers in their areas who participate in community projects. The local law enforcement agencies have also been known to be helpful in supporting community agencies working with children and adolescents with SED.

CASSP Regional Teams report on progress in expanding and developing services, such as school-based and summer programs in rural Arkansas for children and adolescents with serious emotional disturbance. Mental health services are coordinated through multi-agency staffings that provide individualized child/family treatment plans called a MAPS. There are three programs under DHS that provide these wraparound services. Together We Can (TWC) and CASSP teams often meet together in rural counties where these programs are offered to pool resources. CASSP Team members have become active in providing health fairs and other community activities that involve families who would not ordinarily come in to a clinic for outpatient services. ACTION for Kids is a wraparound children's initiative funded through SAMHSA. They provide services in 4 rural counties in the Delta region. Other areas in need of development and expansion have been identified by the CASSP Regional Teams. Some needs are unique to the area, while others, such as transportation, continue to be a problem throughout

the State, but are especially problematic in the more rural areas. Community -based services for dual-diagnosis (MH/SA and MH/DD) clients are still very limited. Very few options for responding to a crisis (e.g., observation beds) are available, other than referral to inpatient services.

Arkansas

Child - Transformation Efforts and Activities in the State in Criteria 4

Child - Describes mental health transformation efforts and activities in the State in Criteria 4, providing reference to specific goals of the NFC Report to which they relate.

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C. Transformation Efforts and Activities

Recommendation 3.1: Improve access to quality care that is culturally competent.

The growth in the minority population has mostly come from the Hispanic community. In an attempt to overcome barriers which have surfaced in the formal mental health system, efforts have been focused on trying to increase hiring of minorities in the local community mental health centers when there are job openings and encouraging client use of the network of natural support systems such as extended family members, friends, churches, and self-help organizations. The goal is to provide services that are culturally sensitive and responsive to the special needs of these children and families.

The SOC Planning Committee has a Cultural Competency Workgroup that will be making recommendations to the Children's Behavioral Health Care Commission who will provide advice and guidance to DHS and other state agencies providing behavioral health care services to children, youth and their families. The mental health system should encourage, on both the state and local levels, early educational opportunities for children and eliminating any disparities in availability and access to mental health care. An ethnic minority representative serves on the CASSP Coordinating Council, and the Council has provided cultural diversity presentations to its members. The community mental health centers provide in-service training on cultural issues as a part of their staff orientation. In addition, the Annual Mental Health Institute agenda as a practice include sessions on cultural diversity issues.

Recommendation 3.2: Improve access to quality care in rural and geographically remote areas.

In rural Arkansas, the Community Mental Health Centers have increased services to the rural population and minorities through their school-based mental health programs, after school and summer programs. They have found that the demand is much greater than the financial and human resources that are available in most areas of the state. Recommendations from several SOC workgroups that will go to the Children's Behavioral Health Care Commission is to consider providing Tele-education training and Long Distance Learning to reach families and service providers in rural areas of the state.

Recommendation 6: Technology is used to access mental health care and information.

In rural Arkansas, the Community Mental Health Centers have found that the demand is much greater than the financial and human resources that are available in most areas of the state. Several of the CMHCs are using teleconferencing to reach staff and families for access to meetings in other parts of their catchment area. Also, several of the SOC Workgroups will make

recommendations to the Children's Behavioral Health Care Commission that they consider approving the use of Tele-education training and Long Distance Learning to reach families and service providers in rural areas of the state.

Arkansas

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

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Criterion 5: Management Systems
A. Resources for Providers

Management Systems

The presentation of a complete picture of the sources and levels of financing for children and adolescents with serious emotional and mental disorders is difficult because each of the key agencies serving the population has its own unique budgeting and expense monitoring procedures. Further, services for children with serious emotional and mental disorder are not program or cost-center specific, but are provided within programs that serve a broader population of clients. For example, outpatient services are frequently not tracked separately for children and adults. In addition, the development of an accurate financial presentation is complicated by the fact that definitions of children and adolescents with serious emotional and mental disorders differ among agencies, thus creating additional difficulties for cross-agency comparisons. Given these limitations, the following table documents the major funding sources for the target population.

Behavioral Health Expenditures for Arkansas State Agencies
State Fiscal year 2006

- Division of Behavioral Health Services $4,922,746 (2006)
- Division of Children & Family Services $ 14,904,589
- Division of Developmental Disabilities "Together We Can" Program
- $389,959 (SSBG Allocation)
- Division of Medical Services (Medicaid) $201,199,542 (Early reports indicate a significant increase in expenditures for 2006)
- Division of Youth Services $4,958,252
- Child Care and Early Childhood Education $300,000
- Behavioral Health-Alcohol and Drug Abuse Prevention $1,468,924 (Residential Services)
-

The primary source of funding for mental health services for children and adolescents is Medicaid, which is administered by the Division of Medical Services. Title XIX (Medicaid) supports a substantial level of services for the target population. The Divisions of Behavioral Health Services and Children and Family Services also receive funds for children and adolescents with emotional disorders. Funds managed by these Divisions come primarily from two sources, state general revenues and federal funds. All contracts through DHS are now performance-based, which includes the contracts with CMHCs for children's mental health services. The data available to DBHS is limited regarding total financing of mental health services in the Arkansas. First, no private insurance or self-pay resources information is available. Second, DBHS has had unreliable data from the CMHCs in the past. This information

should be dramatically improved with the DBHS' enhance data system that is currently being implemented.

Staffing and Human Resource Development

Recognizing that the issues of labor force development, training and retention are critical, Arkansas has implemented several strategies that are designed to address these problems that are common to a number of states. Collaboration with other agencies and programs is an important strategy being used by Arkansas to address staffing and human resource issues. Emphasis has been put on building the system by hiring more paraprofessionals, and providing the opportunities for pre-service and in-service training to staff from multiple systems that work with the target population.

There is some concern about the managed care authorization process that is in place for the U-21 Medicaid eligible population. CMHCs have had to hire additional staff to deal with the "process" which calls for the use of more administrative office staff, and not staff that are working with children. In some areas, CMHCs have lost staff that they can not afford to replace. This has led to loss of resources, which negatively affects access and availability of services.

With the use of block grant funds, changes in the system are gradually taking place to accommodate the movement to least restrictive community-based services. The development of the Children's Behavioral Health System of Care Plan will require new roles, funding, training of new staff, and re-training the existing staff. DBHS will take a lead role in providing technical assistance and training on System of Care (CASSP) guidelines for CASSP teams throughout the State. The SOC will also require development of cooperative relationships with programs that can provide that training, the use of consumers (youth and families) as full participants in the system, and interagency collaboration with other agencies and systems that impact children and adolescents with serious emotional disorders.

Arkansas

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

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B. Emergency Service Provider Training

Emergency Services

Provisions are made by each CMHC to arrange in-service training and training for providers of emergency health services regarding mental health. Local hospital emergency rooms have knowledge of CMHC hotline numbers if needed. Also, the Assistant Director of Forensic Services trains approximately 125 law enforcement officers annually at the Little Rock Law Enforcement Training Academy, and he also provides training at the State Academy. Through DBHS, technical assistance and training is offered to judges, law enforcement, and prosecutors on specific cases that require emergency intervention. The Division of Behavioral Health Services has implemented the following activities:

- Providing ongoing training with officers on a regular basis.
- Providing training specifically for the Central Arkansas (Little Rock) police department at their Academy twice each year.
- Providing sex offender management training sessions annually to police, law enforcement, courts and mental health providers.

Other Training Activities

- The CASSP Coordinating Council meets monthly at the Division of Behavioral Health Services. The Council has 48 members who are appointed by the Directors of the Departments of Human Services and Education. These members represent state agencies, consumers and family members, advocacy groups, mental health providers (both public and private), and other stakeholders in children's mental health. The Council continued their CASSP Presentation Series in 2006-2007 as in-service training for the Council. Members of the Council and other invited speakers provided mini workshops on mental health issues, and how Council members' agencies interface with mental health.
- DBHS provides training and research support for the system through the Research and Training Institute (RTI) operated in collaboration with the adjacent University of Arkansas for Medical Sciences (UAMS).
- During 2006-2007, CASSP site visits were held at 14 community mental health centers in the State.
- Staff participates in a disabilities awareness campaign called "Can Do-Believe Achieve Campaign." This committee makes presentations and has launched a media campaign on removing the stigma of people with disabilities.

- CASSP staff participated in four PATH site visits for 2006-2007. These visits were helpful in knowing if children and families are benefiting from the homeless grant, and how many families use these resources.
- The Division of Child Care and Early Childhood Education continued to fund three pilot projects to support an evidence-based system of care through prevention, early intervention, and treatment services. In addition, the Division of Behavioral Health Services, Division of Child Care and Early Childhood Education, and the Head Start Collaborative have provided ongoing training for community mental health center early childhood liaisons to improve mental health services for young children.
- Training on both the local and national level has been provided for the participants of the System of Care-ACTION for Kids federal grant.
- Site visits were held by DCFS staff and CMHC staff around the State on the DCFS/Mental Health agreements they have for services to be provided in a timely manner to foster care children.
- Cliff Davis, Consultant came to Arkansas in June to hold mini-trainings called "System of Care 101." These activities took place in 7 regions of the state with widespread participation from stakeholders, policy makers and providers.
- The Annual Mental Health Institute is held in August of each year. Mental health consumers, family members, policy makers, providers and other stakeholders receive information pertaining to behavioral healthcare delivery, new treatment and service management technologies, and skills for effective diagnostic and treatment interventions. For the first time in the Institute's history, there will be a youth panel of consumers who will tell their stories and share from their perspective, better ways to serve them and other youth who may be in situations similar to that of their own. The conference also provides other pertinent workshops on children's issues. The Institute brings together over 1,000 mental health consumers, family members, providers, and policy makers from Arkansas and surrounding states.

Recommendation 5.3: Improve and expand the workforce providing evidence-based mental health services and supports.

Through training activities and collaboration with other child-serving agencies, DBHS has worked to improve not only the services provided through CMHCs but also through other programs and projects that include evidence-based services and support. DCFS contracts with CMHCs to provide therapeutic foster care, and three early childhood programs are funded jointly by DCCECE, DBHS, and the Head Start Collaboration Office. SOC plans include improving and expanding the workforce using other evidence-based services and supports. Emphasis will be placed on retraining and training the current workforce to prepare them to function within the System of Care principles. Cliff Davis, Consultant came to Arkansas in June to hold mini-trainings called "System of Care 101." These activities took place in 7 regions of the state with widespread participation from stakeholders, policy makers and providers.

Arkansas

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

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C. Grant Expenditure Manner

Block Grant Funds Allocation

Block Grant funds will be allocated to the private non-profit community mental health center for the purpose of supporting the services goals and objectives delineated in criteria 1-5 of the State's plan for children/adolescents with serious emotional disturbance, as well as addressing the specifics of the CASSP regional plans developed for each geographical area. These funds will be allocated on a per capita basis (2000 census population ages 18 and below). The grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services.

TABLE 2. SFY 2008 FEDERAL BLOCK GRANT ALLOCATIONS

COMMUNITY MENTAL HEALTH CENTERS	SMI Adult	SED Child	Total
Community Counseling Services	$135,766.44	$73,743.09	$209,509.53
Counseling Associates	$172,438.91	$110,925.09	$283,364.00
Counseling Clinic	$67,049.59	$43,031.13	$110,080.72
Counseling Services of Eastern Arkansas	$112,967.45	$89,221.43	$202,188.88
Delta Counseling Associates	$67,202.53	$45,698.83	$112,901.36
Little Rock Community Mental Health Center	$145,543.90	$92,237.01	$237,780.91
Mid-South Health System	$200,906.42	$129,675.87	$330,582.29
Health Resources of Arkansas	$184,009.66	$104,074.82	$288,084.48
Ozark Counseling services	$88,698.29	$46,497.73	$135,196.02
Ozark Guidance Center	$280,583.34	$182,451.50	$463,034.84
Professional Counseling Associates	$193,898.06	$127,574.47	$321,472.53
South Arkansas Regional Health Center	$100,049.32	$64,799.51	$164,848.83
Southeast Arkansas Behavioral Healthcare Systems	$115,802.25	$74,906.04	$190,708.29
Southwest Arkansas Counseling and Guidance Center	$91,768.96	$62,839.69	$154,608.65
Western Arkansas Counseling and Guidance Center	$189,908.66	$128,383.48	$318,292.14
CMHC Subtotal	$2,146,593.78	$1,376,059.69	$3,522,653.47
ADMINISTRATION			$402.78
GRANT TO AR. COUNCIL OF CMHC's			$10,000.00
GRANT TO NAMI-ARKANSAS			$85,000.00
GRANT TO GAIN			$90,000.00
TOTAL			$3,708,056.25

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	9,775	9,775	9,775	9,775
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To maintain or expand access to mental health services for children and adolescents with SED that are seen by the Community Mental Health Center

Target: Forty percent of children and adolecents in the state SED population will receive services through the public mental health system

Population: Children and adolescents with SED who are receiving public mental health services

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Percentage of children and adolescents

Measure: Percent of children and adolescents with SED that receive services through the public mental health system

Sources of Information: DBHS' Enhanced Data Reporting System, Service Process Quality Management (SPQM)

Special Issues: These projections are based on the use of a more recent estimate of the incidence and prevalence in the state of serious emotional disturbance among children ages 9-17.(2006)

Significance: Setting quantitative goals for the percentage of children and adolescents with SED to be served by the public mental health system is a key requirement for the mental health block grant.

Action Plan: DBHS' contracts with community providers specify those with SED as a priority service population. The enhanced data system now used will allow DBHS to publish this information by each provider on a monthly basis, starting in SFY 2008.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	25	16.10	25	25	25	N/A
Numerator	21	9	--	--	--	--
Denominator	83	56	--	--	--	--

Table Descriptors:

Goal: To monitor the number of short-term readmissions to the Arkansas State Hospital.

Target: Percentage of adolescents readmitted to the Arkansas State Hospital within 30 days of discharge.

Population: Adolescents who are re-admitted to the State Hospital.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adolescents readmitted within 30 days of discharge from the Arkansas State Hospital

Measure: Numerator: Number of discharges of adolescents followed by readmission within 30 days of discharge. Denominator: Total number of discharges of adolescents from the Arkansas State Hospital.

Sources of Information: Arkansas State Hospital Reporting System.

Special Issues: In order to be able to report 180 day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year rather than the most recent state fiscal year. Discharges will include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded in the future years. The Adolescent Unit of the hospital has only 16 beds, which will impact the validity of the readmission rates reported.

Significance: Development of more intesive aftercare services with comprehensive community-based mental health services could reduce readmissions to the Arkansas State Hospital.

Action Plan: Readmissions at the established time intervals will be monitored for the required performance indicators, but the significance of the data is diminished due to the low number of beds at ASH.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	41	21.40	35	35	35	N/A
Numerator	34	12	--	--	--	--
Denominator	83	56	--	--	--	--

Table Descriptors:

Goal: Intermediate term readmission to the Arkansas State Hospital will be reduced to the extent possible.

Target: Fewer than 35% of adolescent patients discharged from the Arkansas State Hospital will be readmitted within 180 days of discharge.

Population: Adolescents discharged from the Arkansas State Hospital

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of adolescents readmitted within 180 days of discharge from the Arkansas State Hospital

Measure: Numerator: Number of discharges of adolescents followed by readmission within 180 days of the discharge. Denominator: Total number of discharges of adolescents from the Arkansas State Hospital.

Sources of Information: Arkansas State Hospital Data System

Special Issues: In order to be able to report 180 day readmissions, and for the 30-day and 180- day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year rather than the most recent state fiscal year. Discharges will include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded in future years. The adolescent unit of the Arkansas State Hospital only has sixteen beds, which will impact the validity of the readmission rates reported. The reason no actual data is entered for 2004 is that this was a new indicator introduced for 2005.

Significance: A hallmark of an adequate aftercare with comprehensive community-based services is the ability to avert rehospitalization within an intermediate time period following discharge.

Action Plan: Maintaining a low rate of 180 day readmissions is accomplished by assuring prompt, appropriate, coordinated and ongoing aftercare. DBHS' contracts with CMHCs require that they make aftercare appointments for person being dischareged from ASH available within two weeks of the date of discharge. The ASH social work department contacts each CMHC prior to a patient's discharge and arranges for this timely aftercare appointment. At the time of this contact the ASH socal work staff also bring to the attention of the CMHC the individualized follow up needs of the patient, including current medications and housing needs. ASH social work staff also assess the need for and make appropriate follow arrangements to respond to special client needs including in particular making referral for follow up in therapeutic foster care. In addition to timely and appropriate follow-up, sustained community tenure requires ongoing coordinated services which is accomplished through the system's extensive case management program.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	2	2	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To monitor for increases in evidence-based practices as the System of Care implementation takes place in the State

Target: Number of evidence-based services provided through the CMHCs

Population: Children and adolescents receiving evidence-based services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Children and adolescents in evidence-based programs through the CMHCs

Measure: Number of children and adolescents in evidence-basd programs through the CMHCs

Sources of Information: DBHS's Enhanced Data Reporting System, Service Process Quality Management (SPQM)

Special Issues: DBHS will report on the number of children and adolescents receiving evidenc-based Therapeutic Foster care and Functional Family Therapy through CMHCs. These programs are funded through DCFS, therefore, DBHS does not have control over budget issues that might affect the number of homes/services that are funded.

Significance: Therapeutic Foster Care and Functional Family Therapy are both effective treatment models and should be maintained or increased in order to meet the mental health needs of children and adolescents with SED

Action Plan: DBHS will continue to work with DCFS to maintain these programs, but does not have oversight or control over the funding for these programs. DBHS can only monitor the number of homes available within the CMHC programs, and the number of TFC children and adolescents served.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Therapeutic Foster Care (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	332	311	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To monitor the number of children and adolescents served by evidence-based therapeutic foster care programs within the public mental health system.

Target: Number of children and adolescents in the coustody of the Arkansas Division of Children and Family Services (DCFS) who are served in evidence-baased therapeutic foster care programs through community mental health centers.

Population: Children and adolescent in therapeutic foster care

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Children and adolescents in therapeutic foster care programs through CMHCs

Measure: Numerator: Number of children and adolescents in therapeutic foster care programs through community mental health centers.

Sources of Information: DBHS' Enhanced Data Reporting System, Service Process Quality Management (SPQM)

Special Issues: DBHS will report on the number of children and adolescents receiving evidence-based therapeutic foster care through the CMHCs. Therapeutic Foster Care programs are funded throough DCFS, therefore, DBHS does not have control over budget issues that might effect the number of therapeutic foster homes that are funded.

Significance: Therapeutic Foster Care is an effective treatment model and should be maintained or increased in order to meet the mental health needs of SED children and adolescents in foster care.

Action Plan: DBHS will continue to work with DCFS to maintain TFC programs, but does not have oversight or control over the funding for these programs. Decreased funding for TFC occurred in the last state fiscal year due to budgetary problems. Therefore, DBHS can only monitor the number of homes available within the CMHC programs, and the number of TFC children and adolescents served through those homes.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐ **Indicator Data Not Applicable:** ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Multi-Systemic Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Number of Persons Receiving Family Functional Therapy (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	22	22	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: To monitor the number of children and adolescents served in evidence-based Functional Family Therapy

Target: Number of children and adolescents who are served in evidence-based Functional Family Therapy through the public system

Population: Children and adolescents receiving Functional Family Therapy

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Children and adolescents in Functional Family Therapy through the public mental health system

Measure: Number of children and adolescents recieving Functional Family Therapy through the public mental health system

Sources of Information: DBHS's Enhanced Data Reporting System, Service Process Quality Management (SPQM)

Special Issues: Since annual EBP reporting is new for this year there is no comparable data, thus no trends to report. DBHS will report on the enumber of children and adolescents receiving this service, but these services are funded through DCFS. DBHS does not have control over budget issues that might affect the number of those being served or services funded by DCFS.

Significance: Functional Family Therapy is an effective treatment model and should be maintained or increased in order to meet the mental health needs of children and adolescets with SED.

Action Plan: DBHS will continue to monitor these services, and will work with DCFS to maintain or increase the use of these evidence-based services.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	91	55	55	55	55	N/A
Numerator	3,099	1,911	--	--	--	--
Denominator	3,390	3,464	--	--	--	--

Table Descriptors:

Goal: Maintain the level of satisfaction with outcomes of service by children and adolescents and their caregivers receiving services of the public mental health system

Target: 55% of children and their caregivers surveyed will rate satisfaction with outcomes positively

Population: Sample of children/adolescents and their caregivers receiving public mental health services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of children/adolescents and their caregivers sampled that express positive satisfaction with outcomes of care.

Measure: Numerator: The number of children/adolescents and their caregivers who rated satisfaction with outcomes of care positively. Denominator: Number of children/adolescents and their caregivers who responed to survey items regading satisfaction with outcomes.

Sources of Information: Statewide, random sample, completing the MHSIP consumer satisfaction survey.

Special Issues: Under a contract with the Arkansas Foundation for Medical Care, DBHS conducted in SFY 2006 the public mental health system's first uniformed, system-wide, statistically valid, random sample of consumer satisfaction.

Significance: Achieving consumer-valued outcomes is the ultimate objective of a community-based system of care, and persons satisfied with outcomes of care are more likely to follow through with receiving needed services.

Action Plan: To provide realistic data on satisfaction with outcomes of care of children/adolescents and their caregivers.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	0	0	0	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Reduce suspensions and expulsions in school for children and adolescents with SED

Target: Establish a baseline for decreasing suspensions and expulsions for children and adolescents with SED

Population: Sample of children served in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent of children and adolescents that report decreased suspensions and expulsions from school

Measure: Numerator:The number of children and adolescents surveyed that reported decreased school suspensions or expulsions
Denominator:the number of children and adolescents surveyed that responded to the school survey items

Sources of Information: Children's MHSIP survey with new items addressing school attendence

Special Issues:

Significance: This issue is one of concern for parents and of the public mental health system- to improve school attendance of children and adolescents with SED

Action Plan: DBHS is adding this goal to the Children's MHSIP survey and will be establishing a baseline for this item

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	0	0	0	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Reduce criminal justice involvement of juveniles in the public mental health system

Target: Establish a baseline for decrease in criminal justice involvement

Population: Sample of juveniles served in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent if juveniles sampled that report decreased criminal justice involvement

Measure: Numberator:The number of juveniles surveyed that report decreased criminal justice involvement
Denominator:The number of juveniles surveyed that responded to the criminal justice involvement survey items

Sources of Information: Children's MHSIP survey with new items addressing criminal justice involvement

Special Issues:

Significance: Reducing criminal justice involvement is one of the goals of the public mental health system

Action Plan: DBHS is adding this goal to the MHSIP survey and will establish a baseline for the report of decreased criminal justice involvement

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	0	0	0	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase social connectedness of children and adolescents with SED who are in the public mental health system

Target: Establish the baseline for social connectedness

Population: Sample of children receiving public mental health services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage of children and adolescents with SED that express high levels of social connectedness

Measure: Numerator:The number of children and adolescents with SED surveyed that express high levels of social connectedness
Denominator:The number of children and adolescents with SED surveyed who respond to the survey items regarding social connectedness

Sources of Information: Children's MHSIP survey with new social connectedness survey items

Special Issues:

Significance: Improving social connectedness of children and adolescents with SED is a goal of the public mental health system, and is on of the significant aspects of a recovery-oriented mental health system

Action Plan: DBHS is adding this goal to the Children's MHSIP survey and will be establishing a baseline for this item

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	N/A	N/A	0	0	0	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the functioning level of children and adolescents with SED that are in the public mental health system

Target: Establish a baseline of improved functioning ratings

Population: Sample of children and adolescents with SED who are in the public mental health system

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Percentage of children and adolescents with SED who are sampled that rate themselves as having improved functioning

Measure: Numerator:The number of children and adolescents with SED surveyed who rated themselves as having improved functioning
Denominator:Number of children and adolescents with SED who respond to survey items regarding improved functioning

Sources of Information: Children's MHSIP survey with new functioning level domain items added

Special Issues:

Significance: Improved functioning is one of the primary goals of the services of the public mental health system

Action Plan: DBHS is adding the level of functioning domain items to the MHSIP survey and will establish the baseline for scores in the domain

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Active involvement in multi-agency staffings

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	95	82	80	80	N/A	N/A
Numerator	408	406	--	--	--	--
Denominator	430	497	--	--	--	--

Table Descriptors:

Goal: To increase active involement of caregivers of children and adolescents with SED in multi-agency staffings

Target: 80% of children and adolescentw who have a mulit-agency plan of service developed will have caregiver participation in the process

Population: Children and adolescents with SED

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children with SED who have a caregiver involved in their mulit-agency staffing

Measure: Numerator: Number of caregivers attending mulit-agency staffings through the CASSP process

Sources of Information: CMHC Contract Reporting System

Special Issues:

Significance: A primary goal of the CASSP Coordinating Council and Mental Health Planning Advisory Council is to have more family involvement on both the state and local leves in decisions regarding individualized treatment, monitoring and evaluation of the public mental health system

Action Plan: DHS will be working to build family support in the system of care by working with families to encourage and promote increased family involvement.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑☐

Name of Performance Indicator: Children Receiving School-based Services

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	47	39	47	47	47	N/A
Numerator	8,504	6,531	--	--	--	--
Denominator	18,242	16,588	--	--	--	--

Table Descriptors:

Goal: To maintain or increase access to school-based mental health services for children and adolescents with SED.

Target: Percentage of children and adolescents with SED who are receiving shool-based services

Population: Children and adolescents with SED receiving school-based services provided by CMHCs.

Criterion: 3:Children's Services

Indicator: The percentage of children and adolescents who are receiving school-based mental health services.

Measure: Numerator: Number of children and adolescents who receive school-based mental health services through the CMHCs during the fiscal year. Denominator: Number of children and adolescents with SED who are served through the CMHCs.

Sources of Information: DBHS' Enhanced Data Reporting System, Service Process Quality Management (SPQM)

Special Issues: ***New data reporting systems

Significance: Mental health services provided in the school setting increases accessibility, especially in a primarily rural state where transportation has been identified as a major barrier to services.

Action Plan: Arkansas is in the process of developing a System of Care for children and adolescents with serious emotional disturbances and their families. A recommended strategy under early childhood, is to expand current school-based mental health programs to younger grades.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Number receiving case management

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	56	57	50	50	50	N/A
Numerator	10,193	9,412	--	--	--	--
Denominator	18,242	16,588	--	--	--	--

Table Descriptors:

Goal: To provide case management services for children and adolescents who receive services through the local community mental health centers.

Target: To assess the number of children and adolescents receiving case managment services to use as a basis for setting future targets for expanding services.

Population: Children and adolescents with SED receiving case management services

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of children and adolescents receiving case management services through the local community mental health centers.

Measure: Numerator: Number of children and adolescents with SED who are receiving case management services through the CMHCs during the fiscal year. Denominator: Number of children and adolescents diagnosed with SED through the CMHCs.

Sources of Information: DBHS' Enhanced Data Reporting System, Service Process Quality Management (SPQM)

Special Issues: None

Significance: Assuring that appropriate case management services are available for children and adolescents diagnosed with SED could result in decreased dependence on inpatient services for children and adolescents in Arkansas.

Action Plan: To monitor the number of children and adolescents with SED who are receiving case management services with a goal of decreasing dependence on inpatient services for children and adolescents.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Satisfaction with Access

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2005 Actual	FY 2006 Actual	FY 2007 Projected	FY 2008 Target	FY 2009 Target	FY 2010 Target
Performance Indicator	87	78	78	73	73	73
Numerator	2,023	2,703	--	--	--	--
Denominator	2,317	3,466	--	--	--	--

Table Descriptors:

Goal: Maintain or increase the level of satisfaction with access to services by adolescents receiving services from the public mental health system.

Target: Seventy-three percent of adolescents surveyed will rate satisfaction with access positively.

Population: Sample of adolescents receiving public mental health services.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Percentage of caregivers of adolescents surveyed that express positive satisfaction with access to services.

Measure: Numerator: the number of caregivers of adolescents surveyed who rated access to care positively. Demoninator: The number of caregivers of adolescents surveyued who responded to survey items regarding satisfaction with access.

Sources of Information: Statewide, random sample completing the MHSIP consumer satisfaction survey.

Special Issues: For FY 2005 and before, this indicator was based on aggregated data from provider administered convenience surveys, which varied in specific content among providers. DBHS has now instituted a statewide random sample survey using the MHSIP Youth and Family survey. The goal for FY 2006 was to establish a performance baseline using this new methodology. As seen in the projection for FY 2006, it is anticipated that the new methodology will produce significantly lower satisfaction scores.

Significance: Families satisfied with access to care are more likely to follow through with receiving needed services.

Action Plan: Although the new survey methodology is anticiapted to yield lower satisfaction scores it is the belief of DBHS that these new scores, based on a valid methology, will provide a more realistic basis for assessing the systems performance and planning improvements. DBHS is widely publicizing the survey results including making them available in a consumer friendly Report Card format and available through web-access. DBHS is also in the process of greatly expanding the survey sample size (for children's services in 2006 and adult services in 2007) so that in the future it will be able to produce individual organization level results. This will allow each provider organization to compare its performance with the state average and with other providers. These comparisons will then allow provider organizations to initiate focused quality improvements that it is anticiapted will lead to higher consumer satisfaction scores.

Arkansas

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

ARKANSAS MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

August 23, 2007

Jay Bradford, Director
Division of Behavioral Health Services
4313 W. Markham St.
Little Rock, AR 72205

Dear Mr. Bradford,

The Arkansas Mental Health Planning and Advisory Council (AMHPAC) is pleased to have this opportunity to share with you our experience and thoughts from this years' Block Grant review process.

The Block Grant process began for AMHPAC in January when the regions were instructed to use the FY07 document as a template for soliciting comments, questions and suggestions. This process worked well for us last year, but we only had 4 regions engaged in the process this year. On April 9th, the region comments were received by the State Block Grant Committee and that committee began to compile these comments into one document. Some common themes that emerged from the regions this year are:

- Recovery concepts and how such concepts are driving the services delivery system.
- Rural service delivery issues
- Evidence based practices versus Value based practices
- Stigma and discrimination issues across the state
- System of Care activities and issues

AMHPAC is excited to work with the Division of Behavioral Health Services over the next few years as we begin to weave the Presidents New Freedom Initiative Goals into the Block Grant and then into the service delivery system. The inclusion of the New Freedom Goals into the block grant by CMHS and the state wide initiative of System of Care for Children's Behavioral Health have the capacity to make some radical changes in our state and is an opportunity for education and advocacy for the AMHPAC.

Again Mr. Bradford AMHPAC thanks you for this opportunity to comment on the Block Grant.

Sincerely,

Joyce Soularie, State Chair
Arkansas Mental Health Planning and Advisory Council

Arkansas Mental Health Planning and Advising Council
Minority Letter
4313 W. Markham Street
Little Rock, Arkansas 72205

August 30, 2007

Jay Bradford, Director
Division of Behavioral Health Services
4313 W. Markham Street
Little Rock, Arkansas 72205

RE: Minority Letter for Block Grant 2008

Dear Mr. Bradford:

We represent a minority position of members of the Arkansas Mental Health Planning and Advising Council (AMHPAC) who have several important concerns about the quality of care provided by the Arkansas Division of Behavioral Health Services and the adequacy and appropriateness of the FY 2008 Mental Health Block Grant application. Ultimately, we feel that the concerns result in issues around access and disparity for adult consumers with psychiatric disabilities.

1. There appears to be a lack of ability to conceptualize transforming Arkansas' behavioral health system to one that is a recovery care system driven by adult consumers.
2. There appears to be confusion about access to quality care for adult people with psychiatric disabilities due to being members of a minority (based on past assignment of a psychiatric diagnosis or mental health treatment, President's New Freedom Commission (PNF) §2.5, p. 45) in rural and geographically remote areas of Arkansas and those who are homeless. (PNF, §3.2, p. 52-4)
3. There appears to be rights issues for adult people with psychiatric disabilities in Arkansas for fully integrating into their communities under the *Olmstead* decision. (PNF, §2.5, p. 45)

1. It is imperative that people who develop the State Plan for Arkansas' Behavior Health Services demonstrate current knowledge of Behavioral Health Practices and Knowledge Bases. This knowledge base should include: awareness of national trends; knowledge about tensions between models; what other disciplines are doing; and ability to justify choice and make decisions, based on an understanding of the information. According to SAMHSA's document "A Life in the Community for Everyone", it is noted that "mental health service system transformation is a top national priority." "In this process, laws often must be modified; norms and values, reassessed; and systems of service delivery and finance, changed…. those involved in carrying out the changes as

well as those who will benefit from it must be reeducated to acquire and apply new knowledge needed for the transformation…. If the senior leaders do not own transformation, there is no sense in pursuing it." There are two points that raise questions about DBHS' senior staff being current with the practice of behavioral health care.

a. When AMHPAC met to provide input for the current Block Grant review, there was one or two mentions of "recovery" practices in that previous Block Grant application. When the inquiry about recovery was made, there was an attempt to demonstrate attention to recovery-focused care. Most of the recovery practices are found in the Arkansas State Hospital where a consumer consultant was hired to introduce consumer-driven recovery to the hospital's organizational culture. At the Block Grant review one senior DBHS administrator admitted to not being aware of recovery literature, little less comprehending the requisite fidelity to the recovery models, i.e., multiple perspectives about defining recovery. This can be evidenced throughout most of the programs DBHS oversees. Everything continues to be centered around traditional practices that do not "develop individualized plans of care for every adult with a serious mental illness…." (PNF, §2.1, p. 9). Several senior administrators noted that there is little difference between their interpretations of current services and consumer-driven recovery. Again, referring to SAMHSA's "Life in the Community for Everyone" article, "The rules of the game change, including the norms, guideposts, values, and guides to behavior." DBHS appears to still be trying to 'translate' the vocabulary of one system with the newer, transformed one, which does not grasp the concept of consumer-driven recovery. In very simple terms, even though the underlying values of the care system are not articulated, they determine both available services and quality of care. In other words, if we don't state where we are going, we will still end up somewhere.
b. The underlying logic of educating Arkansans for a recovery-driven transformation is poor. One example of ill conceived logic is the annual Behavioral Health Institute, which is an opportunity to educate many people about the process of transformation as well as what a recovery-driven care system looks like. When reviewing the programs from the last three years there is a dearth of recovery-based presentations. The director of the Mental Health Council of Arkansas remarked at a presentation to AMHPAC that Evidence Based Practices (EBPs) should be altered to make 'sense'. Of course, that lack of understanding speaks volumes regarding the concept of fidelity, a major concept of EBPs. Without an understanding of basic concepts, how can the Mental Health Council make informed choices to move towards consumer-centered recovery? It is also worth mentioning that, based on the 2008 Block Grant, DBHS seems to be gearing up to apply EBPs, a concept that is nationally being recognized as not containing recovery-based values. Also, EBPs are becoming passé nationally. EBPs are also not fiscally sustainable. People do not leave the system. So, DBHS spends $10,000 each year 'educating' attendees at the Behavioral Health Institute without being

guided by a recovery-based vision of transformative practices. The logic seems circular, at best, and certainly not effective in bringing behavioral health practices up to national standards. We question the following statement in the 2008 Block Grant: "In addition to the DBHS-sponsored activities, the CMHCs provide regular in-service training to staff and other providers to keep them informed of current mental health practices and policies." The people who receive care in Arkansas should have access to current practices. Additionally, if applying the same system of care that's been provided for years, (a reductionistic, one-size-fits-all model that supports provider choice while disallowing individual choice that is limited through agency-driven services) that is obviously not a transformation, little less to one that is recovery based. DBHS administrators' inability to grasp recovery-based values (e.g., hope, services centered around individual needs rather than those offered by providers, rights protection, full community integration and self-determination, etc.) and thus lose capacity to implement and apply transformed recovery has profound affect on the other areas of our concern. As noted by SAMHSA, without the vision, insubstantial and insignificant changes will happen. Arkansans with behavioral health care needs will continue to languish. This is tragic when we are capable of recovery and even moving beyond recovery. Mr. Bradford, on several occasions you have mentioned the need to take care of those of us who are consumers and who are the most helpless and vulnerable. Perhaps if the DBHS would explore what consumer-driven recovery looks like and what we consumers can accomplish, you may find that with a little support, we are capable of regaining our lives. We invite you and your staff to begin a dialogue with adult consumers, including goal setting and tracking of changes, to get this process going.

2. There is a huge gap in equitable access to quality of behavioral health services that results from not grasping the concept of individualized plans of care. This applies to individuals who identify as members of a variety of minority populations, including but not limited to race and ethnicity but people with membership in underappreciated groups.

a. First, if adult consumers are marginalized at a forum to provide advocacy for individuals with psychiatric disabilities, i.e., AMHPAC, how can Arkansans expect to protect people who are not even present at the State's Mental Health Planning and Advising Council?

1a. In CMHS's RFA (2007) for Statewide Consumer Network Grants the Glossary defines "Consumer [as] an individual, 18 years of age or older, who has received mental health services". "Consumer-driven: Refers to mental health treatment and related services in which consumers are the primary decision-makers about the care offered and received. Consumer-driven care reflects both the individual and collective consumer voice in all aspects of mental health service delivery including choice of supports, program planning, service implementation, evaluation and research."

2a. In CMHS Consumer Affairs E-News February 9, 2006, Vol. 06-12, the Guiding Principle states that "Consumers are the primary authors and decision-makers in developing policies affecting local, state, and national mental health service delivery…. and are the first and primary stakeholder."
3a. In CMHS's RFA (2007) for Statewide Family Network Grants, family members are identified as [those] who have primary daily responsibility for the raising of a child, youth, adolescent or young adult with a serious emotional disturbance up to age 18, or 21 if the adolescent is being served by an Individual Educational Plan (IEP) or up to age 26 if the young adult is being served by an Individual Service Plan in transition to the adult mental health system."
4a. In a SAMHSA Advisory, dated 12/8/06, consumer supporters [not consumers] "include parents, siblings, spouses, friends, coworkders, and neighbors who provide support in a non-professional capacity."
5a. Arkansas' proposed Block Grant for 2008 repeatedly refers to both AMHPAC and NAMI Arkansas as advocacy representatives for people with psychiatric disabilities. We do not consider either organization as effective advocates for adult consumers with psychiatric disabilities. Both organizations support a one-size-fits-all model of care which perpetuates a non-recovery based care system, disallows our individual rights and ability to live fully in communities of our choice. We acknowledge that some 'one time only' funds were offered to begin establishing a statewide consumer organization. However, there were many strings attached that would have precluded fidelity to consumer values, most probably resulting in a hollow organization that was 'consumer' in name only. This appearance that DBHS is utilizing consumer values is evidenced in the recently created position of Consumer Service Advocate. The token position is staffed by a person who rarely discloses as a consumer and is not conversant with consumer-driven recovery values and does not support many consumer principles, such as self-determination and trauma informed care. Actually, to the best of our knowledge there is not one staff member at the Division who can articulate recovery-driven values. Further, DBHS provides standing funding for both AMHPAC (approximately $40,000) and NAMI Arkansas ($85,000 per year). The Executive Director of NAMI Arkansas recently noted in the minutes of an AMHPAC meeting that consumers and family members are 'one'. As we have stated above, consumers have different perspectives from consumer stakeholders and have been charged with leading the consumer-driven, recovery-based transformation. As one more example of the lack of including adult consumer voice at the AMHPAC table, AMHPAC membership recently "expunged" a state election, disregarding parliamentary procedures and acknowledged publicly that the decision to "expunge" the election was due to personal disagreement with a consumer who supports recovery-based care. When asked to step in and help, you declined. Although supporting the needs of family members is

worthwhile, we feel they are not charged with determining what services work best for adult consumers. We question that statement of in the Block Grant for Transformation Efforts 2.2 "AMHPAC … serves as a strong advocate for orienting the state's mental health system toward recovery. DBHS provides financial, technical and administrative support to this group…. DBHS also provides some financial support to NAMI-Arkansas, another organization which provides consumer and family advocacy for orienting the mental health system toward recovery." We strongly encourage differentiation between consumers and consumer supporters, especially when there is confusion about whose needs are being met. Again, we would like to begin an ongoing conversation to familiarize DBHS with the benefits to all Arkansans regarding transforming to a recovery-driven care.

6a. There is frequent mention of forming a partnership with AMHPAC and NAMI Arkansas to lead the transformation throughout the 2008 Block Grant (ex. "DBHS will also continue the recently begun review with AMHPAC regarding the status of transformation and recovery oriented activities and priorities for advances in these areas.") Many adult consumers support being fully informed to self-determine the best individualized and unique treatment, including alternative treatment and those that are not agency based. DBHS, AMHPAC and NAMI Arkansas are more closely aligned by supporting traditional care approaches of symptom management and stabilization then allowing for choices after the symptoms are successfully 'managed'.

b. Second, even though DBHS names people who live in rural areas of Arkansas and people who are homeless as targeted for priorities, they remain voiceless; so they continue to be overlooked in Arkansas.

1b. There is geographic disparity. The Block Grant cites directing funds towards the Northwest part of the state to expand the bed capacity for acute care. Although the rationale for the decision was based on the statistics that the NW part of Arkansas has the fastest growing population, how is that decision in keeping with the concept of providing care for all Arkansans? Many people who live in the SE part of the state live in the most region that is the most economically challenged. Where is the advocacy for them?

2b. Recently Arkansas' newly elected governor's wife conducted a state-wide tour to gather information about the concerns of many parents who have children and youth with serious emotional disabilities. Some people volunteered to invite her to their region. The plans fell through. When asked about what happened, they were told by AMHPAC's state chair during a state meeting that the tour was primarily for publicity. Again, there appears to be a disparity to getting the voice of all people included in Arkansas, little less having access to equitable services. As noted, the vision for the state's future involves services that are 'consumer-driven

and provided in response to consumer choice." If people are not represented or are marginalized, how will services be consumer-driven and who will make the choices?
3b. People who are homeless are not present and not represented, thus are not speaking for themselves.

3. Most people in Arkansas, including the professional staff, policy makers and many consumers of mental health services, are not aware of the concept of mental health recovery or the wide array of options that support and facilitate recovery, including person centered planning, identifying meaningful roles in life, building confidence, hope and motivation for recovery. Without attention to these and other similar approaches, it is virtually impossible to support adult consumers fully integrating into their communities, especially as delineated under the *Olmstead* decision. This involves Recommendation in Section 2.5 of the President's New Freedom Commission, "Protect and enhance the rights of people with mental illnesses."

a. In Arkansas and at DBHS there appears to be poor understanding of the difference between community-based services that are centered around services driven by providers and services driven by consumers. It is the difference between community-based segregation and full community integration. Currently in Arkansas there are no standardized provisions for the inclusion of informal support options and community links in addition to the available formal mental health services. Consumers have a right to have personally defined goals that lead to living in the most inclusive community settings. Consumers should have access to a personalized mix of formal and informal services and supports that assist in achieving each person's goals, ex. individual budgets and supported employment.
b. In keeping with another recent CMS grant opportunity to encourage states to improve infrastructure (the Person-centered planning RFA), we would like to see infrastructure developed that assure the following services:
    - shifting to person-centered planning
    - shifting to financing mechanisms that support increased consumer (not consumer supporter) control like brokerages and fiscal intermediaries
    - expand the range of choices of services and supports available, for example: peer specialists, not to be confused with the out-of-date paraprofessional model; consumer-run programs that are based on multiple perspectives of recovery models
    - expanding the use of personal assistance services.

In closing we would like to make one more point. We have heard you mention that it is DBHS's responsibility to protect those of us who are most vulnerable. We would like to extend an invitation to you to learn more about us. Conservatively, recovery occurs over 50% of the time when the System provides even minimal rehabilitation. If given a

chance we consumers are a pretty resilient group of human beings. Please, help us to help ourselves. Please give us a chance!

Respectfully and sincerely,

Signed:

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cc.: A. Kathryn Power, M.Ed.
Director, SAMHSA CMHS

Arkansas

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.